2020 IMPACT ASSESSMENT REPORT OF THE UNFPA MULTI-COUNTRY RESPONSE TO THE SYRIA CRISIS: IRAQ, JORDAN, SYRIA, TURKEY AND TURKEY CROSS-BORDER PROGRAMMES

Restoring Balance

ASSESSMENT REPORT

Foreword

The year 2020 constituted one of the most challenging periods within the span of the Syria crisis, which will pass the decade mark in March 2021. In addition to suffering the effects of years of instability, people inside Syria and in refugee communities region-wide also faced the impacts of the COVID-19 pandemic, which further complicated the array of challenges besetting them.

As in years previous, UNFPA continued to show up where it is most needed, working with the international community to ensure that people in need, particularly women and girls, are consistently provided with quality sexual and reproductive health (SRH) services as well as protection from gender-based violence (GBV). Over the course of the year, UNFPA's regional response to the Syria crisis has enabled more than two million individuals to receive SRH services, while more than a million were offered some form of protection from or response to GBV.

Impact assessments remain a core practice in ensuring that these services and the facilities that provide them are not only up to standard but also accessible and impactful. In recent years, UNFPA has published a total of three impact assessments, all of which showed overwhelming and consistent satisfaction rates among those accessing these services.

In this publication, the UNFPA Arab States Regional Office is proud to share the findings of the fourth impact assessment of UNFPA's multi-country response to the Syria crisis, spanning operations inside Syria (including cross-border operations), Iraq, Jordan, and Turkey. As detailed in this report, the findings continue to show the effectiveness and necessity of the services being delivered by UNFPA and its partners in the region, with 99.5 percent of participants offering positive feedback. The key indicators of the assessment have been summarised in a fact sheet that can be accessed here.

UNFPA is grateful to the courageous women, girls, and other respondents whose transparent inputs continue to allow service providers to tailor their services according to the needs on the ground. We are also immensely grateful to all donors and implementing partners whose support has enabled the delivery of a wide array of programmes geared toward women and girls region-wide. The achievements registered in 2020 were made in spite of the unprecedented challenges imposed by COVID-19, and have established yet another solid foundation on which to build as we continue to respond to this multifaceted crisis.

Sincerely,

Luay Shabaneh

Regional Director / Arab States

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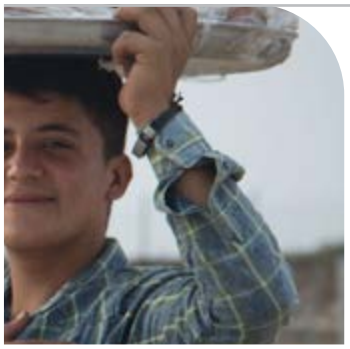


FIGURES

ACRONYMS

3RP	Regional Refugee and Resilience Plan
ASRO	Arab States Regional Office
BEmOC	Basic Emergency Obstetric Care
CEmOC	Comprehensive Emergency Obstetric Care
CFF	Client Feedback Form
CMR	Clinical management of rape
CO	Country Office
CPD	Country programme document
CVA	Cash and voucher assistance
ECHO	European Community Humanitarian Office
EmOC	Emergency Obstetric Care
ESSN	Emergency Social Safety Net
FCDO	Foreign, Commonwealth and Development Office
FGD	Focus group discussion
GAC	Global Affairs Canada
GBV	Gender-based violence
GBV IMS	Gender-based violence Information Management System
HRP	Humanitarian Response Plan
IAF	Impact assessment framework
IASC	Inter-Agency Standing Committee
ICO	Iraq Country Office
IDP	Internally displaced person
IEC	Information, education and communication
IGA	Income-generating activities
IP	Implementing partner
IPA	Individual protection assistance
JCO	Jordan Country Office
MHC	Migrant Health Centre
MHPSS	Mental health and psychosocial support
MoH	Ministry of Health
PLW	Pregnant and lactating women
PSEA	Protection from sexual exploitation and abuse
PSS	Psychosocial support
PVE	Prevention of violence and extremism
SCO	Syria Country Office
SIDA	Swedish International Development Agency
SRHR	Sexual and reproductive health and rights
TCO	Turkey Country Office
TPM	Third-party monitoring
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Agency
UNSCR	United Nations Security Council Resolution
WGSS	Women and Girls Safe Space
WoS	Whole of Syria

Executive Summary

Executive Summary

BACKGROUND

This assessment report is the 4th regional external assessment of UNFPA programming in the Syria regional response, commissioned by UNFPA ASRO Hub.[1] It builds on the previous annual assessments conducted with three primary differences: (a) previous assessments have been conducted per donor and 2020 will see one overall coherent programme impact assessment, inclusive of country-specific chapters, that will be shared with all donors; (b) the COVID-19 pandemic was integrated fully throughout the assessment both in terms of the impact on beneficiaries and adjustments to the assessment methodology; and (c) the inclusion of the use of cash mechanisms within the 2020 assessment.

The overall aim of the 2020 Impact Assessment is to *"examine if services provided at UNFPA-supported delivery points (health facilities, women and girls' safe spaces (WGSS), outreach points and youth centres) are achieving the intended objectives"*.[2] This includes assessment and review to measure, primarily: (a) whether UNFPA-supported services have contributed to improved physical and psychosocial wellbeing of those in need of gender-based violence (GBV) prevention and response services and those in need of sexual and reproductive health (SHR) services; and (b) whether UNFPA-supported services have increased availability, accessibility, and acceptability of quality GBV and SRH services.[3]

APPROACH AND METHODOLOGY

The primary foundational approach to the 2020 Impact Assessment methodology is to build on the framework of previous assessments and to rationalise and systematise the different tools and questions into one overarching Impact Assessment Framework (IAF). A qualitative mixed method was employed.

The IAF was the primary document that coded all questions the impact assessment intended to answer. From this framework, specific questions were extracted for different service delivery points and different data collection tools as was relevant. The IAF also framed the impact assessment evidence database (IAED) so all evidence collected, regardless of data collection methodology (FGD, KII or CFF – or secondary data sources) or service delivery point (WGSS, HF, YC) could be categorised according to the coded question and the evidence was then analysed to produce the findings in the following section by (a) in totality; (b) by service delivery point; and (c) by specific country.

In addition to an extensive document review, the assessment collected primary data from:

125

key informants

337

Focus group discussion (FGD) participants

2029

client feedback form respondents from 63 facilities

1 "The Hub was established in 2012, as part of the Arab States Regional Office (ASRO) structure, in response to the need to scale up the UNFPA Syrian Humanitarian Crisis response, to allow a more effective UNFPA representation at the different humanitarian coordination forums, increase the effectiveness and visibility of humanitarian response activities, and enhance resource mobilisation efforts. The Regional Humanitarian Coordinator joined in February 2013. The Hub capacity was subsequently strengthened by adding personnel in the areas of gender-based violence programming, communications, and monitoring and evaluation. The Hub activities are funded from ASRO regular resources and extra-budgetary funding as well as from co-financing provided by a major donor. As from 2014, pursuant to the "Whole of Syria" approach to the Syrian crisis, the Hub has also been assigned the overall coordination role of cross-border assistance to the population leaving in the southern and northern providences of Syria, which is provided primarily by the UNFPA Jordan and Turkey Country Offices." [UNFPA. Audit of the UNFPA Response to the Syrian Humanitarian Crisis. Final Report. 2017]

2 UNFPA. Impact Assessment Framework Draft 2020. 2020.

3 Note that this question will include a sub-question on community engagement with respect to acceptability of services.

The most satisfied beneficiaries across all countries were

WGSS beneficiaries, with **51%** reporting that accessing services through the **WGSS** was **"absolutely essential"** to their wellbeing.

40% For **health facilities**

27% For **youth centres**

FINDINGS

Women and Girls' Safe Spaces: The impact of all services is high, as reported by beneficiaries themselves. The most satisfied beneficiaries across all countries were WGSS beneficiaries, with 51% reporting that accessing services through the WGSS was "absolutely essential" to their wellbeing. For health facilities this figure was 40% and for youth centres 27%. This is critical information: **WGSS provide absolutely essential life-saving, critical services**. While it is clear that historically, WGSS have been seen broadly within the humanitarian community as a 'nice to have but not necessary to have' this information clearly highlights the impact on physical and psychosocial wellbeing that access to WGSS has for women and girls, and therefore should be considered an essential life-saving service.

WGSS across all countries within this assessment provide a range of services including case management services, referrals, counselling, psychosocial support, awareness sessions, distribution of dignity kits, vocational trainings, specific adolescent awareness and life skills courses. WGSS FGD participants highlighted a number of important benefits of accessing WGSS, including the *"psychological comfort"* of the spaces; the change in daily routine and the alleviation of boredom; access to a diverse range of free services; *"kind and gentle"* service providers; and friendship support. Beneficiaries all highlighted that accessing services *"lifted their spirits"* as well as developing new skills, increasing confidence, and meeting new people. Adolescent girls in particular highlighted the increase in self-confidence that came from accessing adolescent girl activities within WGSS.

The most requested improvement across all contexts was having more income-generating activities with linkages to employment / building capacity and particularly having these aimed at more vulnerable individuals, such as those with disabilities.

One issue that arose was that of provision of services to men and boys through the WGSS model. Women themselves requested that more male awareness courses be offered to their husbands, with regard to gender equality which they believe would increase their safety at home. However, WGSS facilities being used for male activities is problematic and against global guidelines – developed by UNFPA – for WGSS.[4]

4 The issue of WGSS being preserved for women and girls only is referenced in the UNFPA own guidance note on WGSS – https://www.unfpa.org/sites/default/files/resource-pdf/UNFPA%20UNFPA%20Women%20and%20Girls%20Safe%20Spaces%20Guidance%20%5B1%5D.pdf; and also in the Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming - https://www.unfpa.org/sites/default/files/pub-pdf/19-200_Minimun_Standards_Report_ENGLISH-Nov.FINAL_.pdf; and also in the latest IRC/IMC WGSS toolkit - https://reliefweb.int/sites/reliefweb.int/files/resources/IRC-WGSS-Toolkit-Eng.pdf

Across all countries there is a common theme of UNFPA-supported WGSS providing quite unique services. An overwhelming majority of beneficiaries reported easy access. In terms of awareness of services, WGSS beneficiaries across different countries generally cite family, friends, neighbours and 'word of mouth' as the most common way of hearing about UNFPA WGSS services. Almost all WGSS beneficiaries across all countries think opening hours of centres are convenient.

There was a range of responses with regard to sufficiency of staffing pre-COVID-19, with generally no gaps in WGSS staffing reported in Syria but across Iraq, Jordan, Turkey, and Turkey cross-border, respondents reported an inadequate level of staffing. Turkey in particular struggles with enough translators, a challenge not faced by other countries. WGSS staff across all Syria regional response countries have received significant training, with most common topics being: GBV in general; GBV case management; psycho-social counselling and support (PSS); management of referral pathways; confidentiality protocols; project management (Jordan only); working with people with disabilities; SRHR.

Overall there was a wide range of responses with regards to supplies. Iraq, Turkey and Syria reported some shortage of supplies at different times and Turkey cross-border partners reported delays in receiving some supplies that were procured from outside Syria. Generally, however, the supplies issue was not reported as being dire anywhere. Jordan reported no supply issues but did refer more to infrastructure, with some partners highlighting the need to improve physical space, for example for fire safety, and to have dry (covered) outdoor space – specific to COVID-19 considerations – so they could conduct activities more safely. In respect of COVID-19, some countries reported a lack of quality masks, or lack of masks for beneficiaries, but this was less important than the reported shortage of computers, phones (with camera) and internet access, which was overwhelmingly highlighted by all countries.

Health Facilities: Across the Syria regional response, UNFPA provides a variety of standalone and integrated SRH facilities. This ranges from midwives and nurses in WGSS settings providing family planning and counselling, through to comprehensive emergency obstetrics care and everything in between. For all countries, women reported that family-planning services and antenatal care are prioritised as the two most important services for them to access and that these are critical to the wellbeing of women and girls. Compared to WGSS, there are many more available health services across the countries that beneficiaries can potentially access, with **a common theme being that these other services are either not free or not of the same quality as UNFPA-supported SRH services.**

In terms of awareness of services, beneficiaries cited similar modalities of learning about services as WGSS beneficiaries – family, friends, neighbours, and 'word of mouth'. Almost all health beneficiaries across all countries think opening hours of centres are convenient.

Syria and Jordan health centres reported no gaps in staffing and no additional staff required for the COVID-19 pandemic. However, both Iraq and Turkey cross-border operations reported both a general shortage of health facility staff and a clear need for additional staff during the pandemic. Iraq highlighted that during the peak of the pandemic, many staff were transferred from the clinics to larger hospitals as part of the COVID-19 response and other staff were absent through being sick or isolating due to high risk (such as pregnancy). Turkey cross-border reported additional staff were required to help raise awareness of COVID-19 and the measures put in place, and access to online support, the need to ensure all infection prevention modalities are in place and being monitored, and regulating entry to hospitals and clinics. Health facility staff across all Syria regional response countries have received significant training, with most common topics being: SRHR; GBV in general; GBV case management; PSS; children and malnutrition; and CMR (Turkey cross-border only).

Both Iraq and Syria reported a general shortage of certain items before the pandemic started, with respondents from Syria linking this specifically to current exchange rate issues in Syria. Iraq and Syria also both highlighted issues with RH kits vis à vis certain contents being inappropriate for the context, and Iraq also reported an issue with short expiration dates of some items. Jordan and Turkey cross-border operations reported no shortage of supplies before the COVID-19 pandemic started and Jordan confirmed this has not changed since COVID-19. However, Turkey cross-border operations and Syria CO both highlighted issues with quality masks and hand sanitiser since the pandemic began (there is an inter-agency response to this for Turkey cross-border operations, with OCHA allocating funds from the Humanitarian Fund for PPE) and Turkey cross-border highlighted that shortages of other medical supplies are increasing since the pandemic began.

Youth Centres: UNFPA operate youth centres to differing degrees across all Syria regional response contexts with the exception of Turkey cross-border operations which focus on WGSS and health

facilities. Youth reported self-development and feeling more self-confident and specifically enjoy the issue of civic engagement and giving back to their communities. **This is important: youth centres are not just about benefiting youth but facilitating what youth can give back to their communities.**

It is important to consider, when opening youth centres to older adults (a) how much this denies services to the UNFPA target audience of adolescent girls, particularly when there are 30 year old married men in the centre so many girls will be unable to be within that same space; (b) how this aligns with the UNFPA mandate and target constituency and (c) what is the duplication of services when married adult women are accessing services through a youth centre rather than a WGSS and why are they accessing youth services rather than WGSS services as adult married women.

For youth centres, there is more of a range across countries vis à vis what other services are available. In terms of awareness of services, beneficiaries cited similar modalities of learning about services as WGSS beneficiaries – family, friends, neighbours, and 'word of mouth'. Most youth found the opening hours convenient.

Youth centre respondents from Iraq, Jordan, and Syria all referenced adequate staffing pre-COVID-19, and Syria reported this not changing. However, Jordan reported already recruiting more outreach volunteers in the youth centre in Za'atari camp in response to COVID-19. Turkey highlighted inadequate staffing in youth centres even before the pandemic, specifically based around the fact that health service providers for the Turkey youth centre model represent a very specific job profile: a role which requires being a qualified medical service provider but also with experience working with youth, experience working with vulnerable refugee populations, and Arabic / Kurdish speaking. Both Turkey and Iraq report requiring more youth centre staff since COVID-19 started. Syria youth centres report managing adequately with current staffing levels. Across all countries, youth centre staff have received various trainings from UNFPA including: life-skills; how to provide educational and vocational training to young people; non-violent communication; gender; GBV; PSS; referral pathways; media and communication; self-care; and peace-building (Iraq only).

Iraq, Jordan and Turkey youth centre respondents all reported no gaps in supplies, although Turkey highlighted that with increased violence and stress in the community, coupled with increased youth unemployment all due to COVID-19, they foresee the need in the future to increase activities and services to youth and therefore shortages of funding and supplies were predicted. Syria highlighted a gap of computers for youth centres. Both Iraq and Turkey highlighted the clear utility of dignity / hygiene kits for youth during this year.

Safety and respect: Across all countries, beneficiaries of all services, through both FGD and CFFs, reported feeling safe and respected in UNFPA-supported facilities and centres, with few exceptions.

Reaching the most vulnerable: In general, UNFPA and partners have made significant efforts to ensure vulnerability is defined, identified, and addressed. However, there are still significant challenges in getting this right.

Specific to adolescent girls, UNFPA teams across all countries have made continuous improvements to ensure this particular category is well-catered for with all countries having multiple mechanisms for ensuring the needs of adolescent girls are met and monitored including specific programmes, focal points embedded in implementing partners, and indicators in Country programme documents (CPDs).

This is also true for people with disabilities. In 2017, there was limited mention of people with disabilities from FGD participants. Most participants reported that the WGSS is open to everyone and did not seem to consider the accessibility issues for those with disabilities. By 2019, key informants across the majority of health facilities reported that beneficiaries with both physical and mental disabilities had recently accessed services. The 2020 assessment highlights clear progress although there is still work to be done to have a consistent and high quality approach to disability inclusion across the Syria regional response. This year, many women and girls with disabilities spoke for themselves during FGDs.

However, some challenges still remain, both in terms of ensuring accessibility (physical and otherwise, and recognising accessibility of the centre itself and accessibility of getting to the centre – i.e. inappropriate roads, and not being able to use public transport as two distinct challenges), and also addressing the strong societal and cultural barriers that prevent people with disabilities, particularly women and girls, from taking their place in society and living their lives to the fullest. The challenges therefore fall into different categories:

- Staff not being trained on disability inclusion (and note in the next section, efficiency, this report highlights that a number of staff across all three service unit types are requesting more disability inclusion training): this includes knowledge, attitude, and practice; recognition of what disability is; understanding the importance of including those with disabilities in all services and activities; and implementing the practical and pragmatic solutions to achieve this;
- Access to the front door of the centre (i.e. external challenges with roads and transport);
- Accessibility into and within the centre (ground floor only, accessible toilets, ramps etc);
- Societal and cultural barriers and stigma.

Cash Assistance: Across the UNFPA Syria regional response countries, at the time of the assessment, cash assistance was currently only used in the Turkey cross-border response for individual protection assistance and case management. Syria was in the process of establishing a large cash and voucher assistance (CVA) programme with WFP, and Jordan had also started some cash programming. This assessment looked at the benefits and challenges of the existing Turkey cross-border cash programming, and within the other countries, collected data on what the potential benefits and challenges of introducing cash might be. UNFPA has recruited a cash and voucher specialist within the Humanitarian Office and this is an area of work UNFPA will be scaling up in the future. All respondents to this assessment agreed that the IPA was extremely impactful and only wanted consideration of more funds allocated to cash and a wider criteria range to capture more vulnerable women and girls. There was also a sense that cash becomes even more important for accessing services during COVID-19 with successive lockdowns where women and girls are often referred to different services that remain open, some of which might not be free.

COVID-19: With regards to COVID-19, some overall common themes across all countries include:

- increases in overall reports of gender-based violence;
- women and girls have continued to highlight throughout the pandemic how critical WGSS services are for their wellbeing;
- youth being more able to access online activities, but also being severely impacted by increased unemployment and reduced income-generating activities;
- younger women and adolescent girls more willing to continue accessing WGSS services – i.e. having less fear of catching COVID-19 – as long as mitigation measures are in place;
- there are certain modalities that UNFPA and partners were forced to adopt for COVID-19, which may be useful to continue after the pandemic to compliment the more traditional face-to-face engagement with beneficiaries, which include hotlines, online counselling and expanded mobile outreach.[5]

All UNFPA countries have put in place a number of specific mitigation measures for COVID-19. These include, across all service units:

1. Physical adaptation of face-to-face services such as: a reduction of number of participants for any activity; commitment to social distancing and use of masks and gloves; allocation of specific tools and equipment for each participation during activities, and sterilisation between uses; putting outdoor waiting chairs with consideration for spacing; reduction of the use of forms that were previously used by women.[6]
2. Provision of online services such as: providing awareness activities through social media applications; provision of online / telephone services; training of service providers for remote service provision.
3. Raising awareness of COVID-19 such as: providing awareness sessions about COVID-19 and how to prevent it.
4. Duty of care to staff and volunteers such as: reducing the number of mobile teams; provision of PPE; reduction of working hours; ensuring all employees have computers, mobile phones, internet, and could work from home; rotating staff who are providing face-to-face services.

5 UNFPA has released a best practices and lessons learned for COVID-19 special knowledge series publication which highlights some of these issues: https://syria.unfpa.org/sites/default/files/pub-pdf/covid-19_best_practices_-_english_-_141020-2_0.pdf
6 No further information was provided on this.

RECOMMENDATIONS

> **The most requested improvement across all contexts was having more income-generating activities with linkages to employment / earning capacity and particularly having these aimed at more vulnerable individuals, such as those with disabilities.**

Many of these recommendations will require additional financial investment from UNFPA, therefore these should be included in upcoming proposals and funding opportunities.

1. **Plan for expansion of gender-transformative interventions including income-generating activities in WGSS.** Income-generating activities (IGA) and vocational skills linked to employment and earning potential are the most requested activities in WGSS across all countries. While all countries currently offer differing levels of services, it might be worthwhile to consider a regional strategy for IGA within WGSS which might involve: (a) partnerships with other agencies (i.e. UN Women or UNDP) or regional or national NGOs, technical institutions, or other organisations or private sector; (b) a review of the types of IGA being offered, noted that women and girls are not requesting any non-traditional skills (activities such as hairdressing and sewing are the most requested) but this presents an opportunity for UNFPA to infuse a more gender-transformative approach within the WGSS model; and (c) recognising that UNFPA is not and should not be advocating for adolescent girls to work, but that that they can learn new skills that are gender-transformative that will later have a positive economic outcome.
2. **Develop interim guidance on addressing male survivors of sexual violence.** While it is clear that that UNFPA ensures the provision of health services for any survivor of sexual violence (women, men, girls and boys), it might be useful for the Syria regional response, under the auspices of the Hub which itself sits under ASRO,[7] to develop some interim guidance on addressing male survivors of sexual violence until global-level guidance is available to assist COs in navigating how to best respond.

7 Noting that there is a complication with Turkey CO and the Gaziantep office for cross-border operations which are under the EECARO region rather than the ASRO region: this would be something internally for UNFPA to manage.

3. **Rationalise male engagement and activities through GBV programming with a clear statement that WGSS are for women and girls only.** The regional Syria regional response, under the auspices of the Hub which itself sits under ASRO,[8] should re-issue guidance to assist COs in navigating the requests from women and girls themselves for activities for their male relatives at the WGSS; with clear examples of how UNFPA should engage men in prevention through accountable practices and how that can work outside of WGSS space; and the clear global guidance to ensure WGSS is critically protected as a women and girls only space.
4. **For youth centres, a rationalisation of the target audience would be useful.** As different COs are aware, there is a range of different definitions of 'youth' and national guidelines are often different from the global definition of youth (being 15-24). With the new IASC guidelines on young people coming out in 2021, UNFPA should ensure that they are rolled out in all its responses. In the short term, UNFPA should ensure that its youth centres are structured to ensure that the provision of services to older men and women does not inhibit the provision of services to the adolescent and early twenties demographic which is the core target audience of UNFPA youth focus.
5. **Adolescent girls: enhance the Hub's ongoing initiatives of sharing good practices, and support the testing and replication of successful interventions in different settings.** The Hub should build on its programme of webinars and briefs for UNFPA CO staff and implementing partner staff to embed continuous learning and sharing on working for and with adolescent girls.
6. **People with disabilities: categorise the specific factors of disability exclusion and map specific actions for each.** While progress has been made in addressing the needs of PWD, UNFPA should go further to ensure they are truly reaching the most vulnerable, by analysing the factors of exclusion. This categorisation should use, as a basis, the four highlighted in this report: (1) societal; (2) the physical environment outside of UNFPA-supported centres; (3) the physical environment inside of UNFPA-supported centres; and (4) knowledge, attitudes and practices of service providers. UNFPA might consider stronger regional partnerships with Humanity and Inclusion (HI) or, if they have limited capacity, any other organisations and institutions.
7. **Create a regional plan for mapping and monitoring the return on investment of IEC and outreach for raising awareness of WGSS.** Most beneficiaries across all service points – WGSS, health facilities, and youth centres – cite 'word of mouth', friends and family (noting that 'word of mouth' is really synonymous with friends and family) as how they heard of services. This is expected and does not pose a problem at all, but to ensure that UNFPA has exhausted all avenues to reach the most vulnerable women and girls (and youth) with information about services, UNFPA could consider investing in pilots to use a more marketing approach to raise awareness about the WGSS. This could support an analysis of the cost-efficiency of traditional awareness as opposed to 'marketing' methods to inform about services.
8. **COVID-19: Institute an ongoing practice of collating and sharing COVID-19 solutions and unexpected positive outcomes.** It would be useful for UNFPA Syria Regional Response Hub to capture best practices from COs on a regular basis with a view to publishing or sharing more widely in 2021 or 2022 with clear evidence of what works and how service provision in the post-pandemic 'new normal' can be maximised for effectiveness and efficiency. It is recommended to talk to IP staff and capture the unexpected positive outcomes of programming during the COVID -19 pandemic, with questions that try to capture any unexpected benefits of adaptation, and what should continue during the new normal.
9. **Country Offices should use the raw data collected in this report to analyse more closely specific issues arising from the feedback.** This report collates a significant level of data to present a regional assessment of the UNFPA response. While there are country chapters, these are also bound by the format of this assessment report as agreed within the inception phase of the assessment and presented at country level, not at the facility level. However, all countries hold the raw CFF and FGD data, which provides rich data at the facility level which countries can use, with support from the Hub, to address any specific localised issue.

8 Noting that there is a complication with Turkey CO and the Gaziantep office for cross-border operations which are under the EECARO region rather than the ASRO region: this would be something internally for UNFPA to manage.

Section 1

Introduction and Methodology

Section 1: Introduction and Methodology

1.1 Overview of the impact assessment

This assessment report is the 4th regional external assessment of UNFPA programming in the Syria regional response, commissioned by UNFPA ASRO Hub.[9] It builds on the previous annual assessments conducted with three primary differences:

1. previous assessments have been conducted per donor and 2020 will see one overall coherent programme impact assessment, inclusive of country-specific chapters, that will be shared with all donors;
2. the COVID-19 pandemic was integrated fully throughout the assessment, both in terms of:
   a. adjusting how the assessment will take place and revising reliance on primary and secondary data collectively; and
   b. ensuring that the realities of how COVID-19 is affecting women, girls, men, and boys who access UNFPA-supported services and what this means for UNFPA programming is integrated throughout the assessment;
3. include the use of cash mechanisms within the 2020 assessment.

Notwithstanding these three main differences, the purpose and objectives of the 2020 impact assessment are similar to previous years, namely:

1. To determine the extent of improved physical and psychosocial wellbeing of those accessing SRH services and participating in GBV programmes (prevention and response);
2. To establish the accessibility and availability of integrated GBV and SRH services for IDPs, refugees, and host communities;
3. specific issues such as resilience, disabilities, and adolescent girls.

The findings of the assessment are intended to inform UNFPA programmes with the overall aim of enhancing the services that UNFPA provides. These findings will also be considered when designing new programmes, and shared with donors funding UNFPA's operations in the Syria crisis region.

1.2 Background and overview of the UNFPA Syria regional response programme

Syria's civil war, ongoing since 2011, has had profound effects on a range of countries in the region and beyond. Within Syria, an estimated 11.7 million people still require humanitarian assistance.[10] Across neighbouring countries, millions more, comprised of refugees and host communities, require humanitarian assistance and protection due to the impacts of the ongoing conflict. In total, approximately 20 million people across the region – IDPs, refugees, and impacted host community members – are considered as vulnerable and in need of humanitarian aid due to the ongoing conflict.

9 "The Hub was established in 2012, as part of the Arab States Regional Office (ASRO) structure, in response to the need to scale up the UNFPA Syrian Humanitarian Crisis response, to allow a more effective UNFPA representation at the different humanitarian coordination forums, increase the effectiveness and visibility of humanitarian response activities, and enhance resource mobilisation efforts. The Regional Humanitarian Coordinator joined in February 2013. The Hub capacity was subsequently strengthened by adding personnel in the areas of gender-based violence programming, communications, and monitoring and evaluation. The Hub activities are funded from ASRO regular resources and extra-budgetary funding as well as from co-financing provided by a major donor. As from 2014, pursuant to the "Whole of Syria" approach to the Syrian crisis, the Hub has also been assigned the overall coordination role of cross-border assistance to the population leaving in the southern and northern providences of Syria, which is provided primarily by the UNFPA Jordan and Turkey Country Offices." [UNFPA. Audit of the UNFPA Response to the Syrian Humanitarian Crisis. Final Report. 2017]

10 UN. Syrian Arab Republic Humanitarian Needs Overview (HNO) Summary 2019. 2019.

In 2014, the Whole of Syria (WoS) approach was introduced across the United Nations, authorised initially by UN Security Council Resolution (UNSCR) 2165 in 2014 which allowed cross-border humanitarian assistance from Iraq, Jordan and Turkey. Successive UNSCRs extended and adapted this, eventually reducing to cross-border assistance from Turkey only. The most recent resolution 2533 on 10th July 2020 extends cross-border aid from Turkey for another year, but reduced down to one crossing point only.

In addition to the Whole of Syria approach under the Humanitarian Response Plan (HRP), there has been a succession of comprehensive Regional Refugee and Resilience Plans (3RPs) since 2014, which aim to coordinate and align responses to Syrian refugees and affected host communities across Egypt, Iraq, Jordan, Lebanon, and Turkey.

Figure 1. Regional Refugee and Resilience Plan (3RP) Annual Report 2019 numbers[11]

Country	Registered Syrian refugees	Directly targeted members of impacted communities	Total
Egypt[12]	129,210	506,000	635,210
Iraq	245,810	158,110	403,920
Jordan	654,692	520,000	1,174,692
Lebanon	914,648	1,005,000	1,919,648
Turkey	3,576,636	1,800,000	5,376,369
Total	**5,520,729**	**3,989,110**	**9,508,838**

The UNFPA response is coordinated through the Syria Response Hub ('the Hub'), agreed upon in 2012 and established in Amman in 2013 following the declaration of L3 crisis level for Syria. This hub was established as part of the ASRO structure, and before UNSCR 2165 or the overall Whole of Syria Response structure. It was established in response to UNFPA recognising the need to scale up the Syria response and improve coordination between different country offices (COs). A regional Humanitarian Coordinator was appointed in February 2013 with further dedicated posts being subsequently created, particularly in the areas of GBV, communications, and monitoring and evaluation.[13] The Hubs TOR have subsequently been updated and the Hub now focuses on knowledge management for all humanitarian operations in the Arab states region.

UNFPA activities across the Whole of Syria and the 3RP refugee countries plans have focused on supporting facilities to provide SRH services including access to family planning; maternal and new-born health (MNH) services including emergency obstetric care (EmOC) (both basic emergency obstetric care (BEmOC) and comprehensive emergency obstetric care (CEmOC); Gender-based violence (GBV) services including access to safe spaces, support to facilities for clinical management of rape (CMR), and GBV prevention messaging. UNFPA has also supported youth empowerment and population programming.

11 UN. 3RP Annual Report 2019. 2019.
12 Note that Egypt is not included within the UNFPA regional programmes and not included within this impact assessment.
13 Audit of Syria Response Syria Response Hub, Jordan April 2017

1.3 Background and Methodological overview of the 2020 impact assessment

The overall aim of the 2020 impact assessment is to *"examine if the services provided at UNFPA-supported delivery points (health facilities, women and girls' safe spaces (WGSS), outreach points and* youth centres) are achieving the intended objectives".[14] This includes assessment and review to measure, primarily:

a. whether UNFPA-supported services have contributed to improved physical and psychosocial wellbeing of those in need of gender-based violence (GBV) prevention and response services and those in need of sexual and reproductive health (SHR) services; and

b. whether UNFPA-supported services have increased availability, accessibility, and acceptability of quality GBV and SRH services.[15]

The specific objectives of this assessment are:

1. to improve programming where possible;
2. to provide primary regional donors (the UK Foreign, Commonwealth and Development Office - FCDO,[16] Global Affairs Canada – GAC, and the Swedish International Development Agency – SIDA), ECHO, Finland, Denmark, Italy and Norway with an overview of the impact UNFPA has on the wellbeing of refugees, IDPs, and host communities, and how their funding has contributed to this.

Scope of this impact assessment includes:

1. ***Temporal:*** due to COVID-19 realities impacting severely on 2020 service delivery, this assessment will review data from December 2019 to June 2020;
2. ***Geographic:*** Syria and Turkey cross-border; Iraq, Jordan, Lebanon, and Turkey;
3. ***Thematic:*** UNFPA programming including service delivery points of health facilities, WGSS, and youth centres.

Audiences:

1. UNFPA Hub and Country Offices in Iraq, Jordan, Lebanon, Turkey, and Turkey Gaziantep office;
2. Primary regional UNFPA donors – FCDO, GAC, SIDA, Denmark, Norway, Finland, ECHO and Italy.

Methodology Overview

The primary foundational approach to the 2020 Impact assessment methodology is to build on the framework of previous assessments and to rationalise and systematise the different tools and questions into one overarching **impact assessment framework (IAF).** See Annex I. A qualitative mixed method was employed.

The IAF was the primary document that coded all questions the impact assessment intended to answer. From this framework, specific questions were extracted for different service delivery points and different data collection tools as was relevant. The IAF also framed the **impact assessment evidence database (IAED)** so all evidence collected, regardless of data collection methodology (FGD, KII or CFF – or secondary data sources) or service delivery point (WGSS, HF, YC) could be categorised according to the coded question and the evidence was then analysed to produce the findings in the following section by:

a. in totality;

b. by service delivery point;

c. by specific country.

14 UNFPA. Impact Assessment Framework Draft 2020. 2020.
15 Note that this question will include a sub-question on community engagement with respect to acceptability of services.
16 Previously the UK Department for International Development, DFID.

Responses from specific demographics (adolescents, older youth, people with disabilities) have been highlighted as such in the IAED. These responses, particularly with any differences to general population responses, will be subsequently highlighted in the findings below.

Simplified, the framework (both IAF and IAED) allowed for assessment across the following dimensions:

Figure 2. Dimensions of the Assessment

Dimension	Title	Explanatory notes
Dimension A	Profile / Respondent / Facility data.	This was collected for disaggregation of data purposes only, and analysis was conducted on the aggregate of the data for each disaggregation theme.
Dimension B	Improved physical and psychosocial wellbeing	This dimension covered services provided, impact of services, what could be improved, why beneficiaries attend and what are the most important services, the overall impact of the services on their lives, the COVID-19 impact, how safe and respected they feel in the service units.
Dimension C	Increased access to services	This dimension covered where else there are similar services, accessibility and challenges to accessibility, how beneficiaries heard of services, convenience of opening hours, if services reach the most vulnerable, how people with disabilities access services COVID-19 question on accessibility, impact and adaptation.
Dimension D	Efficiency	This dimension was for internal UNFPA questions only and included the following aspects: if there are enough staff, staffing during covid-19 times, training received and training needs, COVID-19-specific training needs, equipment / supplies, COVID-19-specific equipment / supplies, RH kits, post-rape kits, challenges.

The IAED was also used to ensure a holistic analysis was performed on the totality of evidence gathered (again, both primary and secondary) and was triangulated and verified within the analysis process.

Ethical aspects were considered in the design and implementation of this assessment aligned with the United Nations Evaluation Group (UNEG) Ethical Guidelines for Evaluation and the UNEG Code of Conduct for Evaluations in the UN System.[17] In particular, the assessment ensured the confidentiality of its informants and responses are used only in aggregate form. All participatory data collection methods were developed to be culturally and gender responsive and aligned with the Do No Harm principle, and designed to give voice to a more inclusive and diverse range of stakeholders.

Limitations – expected and unexpected

COVID-19: The primary limitation for this impact assessment was, of course, the global COVID-19 pandemic. The guiding principles vis à vis COVID-19 used for this impact assessment included:

1. Do No Harm and safety is paramount. This is the first and foremost underlying principle. No data collection methodology will be undertaken if it heightens risk of COVID-19 to beneficiaries, staff, or volunteers. No data collection methodology will be undertaken if it undermines country-level or locality-level measures to contain the spread of the virus. And lastly, no UNFPA staff member, partner staff member, or beneficiary will be asked to participate in any data collection methodology they feel uncomfortable with.
2. The principle of 'good enough' will be applied throughout this assessment.
3. The principle of repurposing assessment to ensure safety while maximising utility (defined as both lessons learned and improving programming and showcasing UNFPA's impact to donors) will be considered throughout the assessment.

17 http://www.unevaluation.org/document/detail/100; http://www.unevaluation.org/document/detail/102

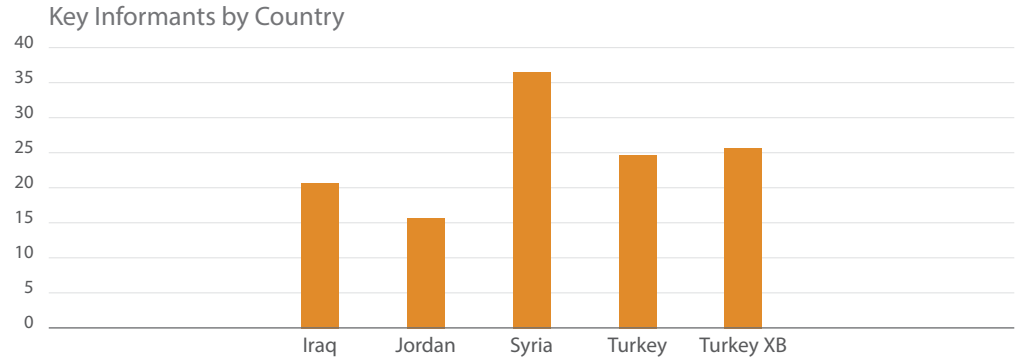
4. The use of secondary data will be maximised.
5. The use of face-to-face interviews and meetings will be minimised.

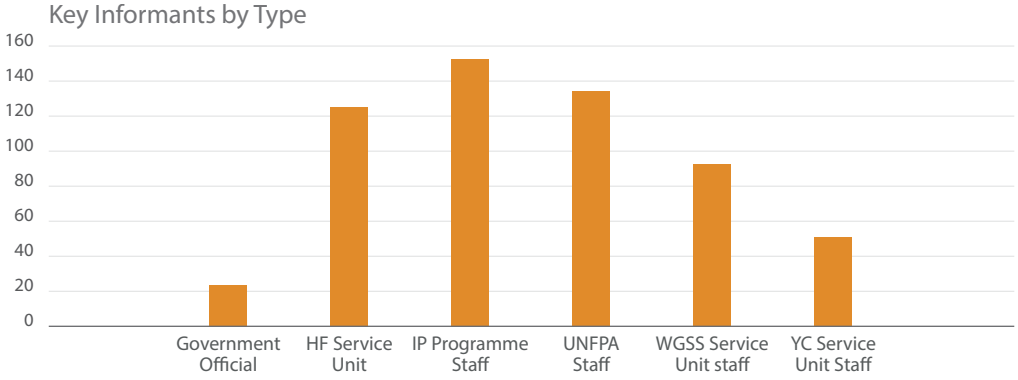
Actual limitations of COVID-19 and generally:

- Iraq CO was unable to conduct FGDs due to COVID-19 restrictions and relied on a hybrid CFF / FGD questionnaire. This has significantly restricted the richness of data collected for Iraq. All other countries were able to conduct FGDs (see numbers below).
- There was a notable difference in the scope of data collected from different countries. For example, as above, Iraq did not conduct any FGDs. Cross-border Turkey conducted three FGDs and had no CFFs, using instead the third party monitoring reports (TPM),[18] while Syria conducted 30 FGDs and 995 CFFs across the different service points.
- **Beirut Explosion:** On 4th August a "catastrophic blast"[19] occurred in Beirut, leading to an estimated 200 people killed, thousands wounded, and 300,000 made homeless.[20] The immediate and large-scale response to this tragedy required by all humanitarian actors in Lebanon, including UNFPA, resulted in Lebanon being excluded from this year's impact assessment, given the unnecessary extra burden this assessment would have placed on the Lebanon country office at that time.

Figure 3. Evidence sources in numbers

125
Key Informants

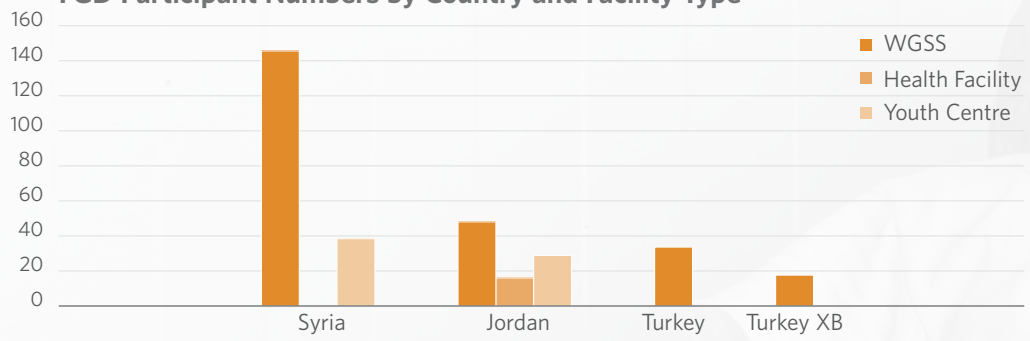




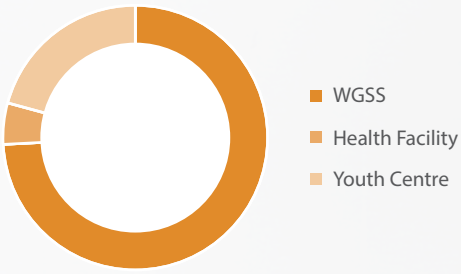
18 while the TPMs provide a lot of similar information which could be extracted in aggregate form for the analysis, it did not align entirely with the framework of questions for this evaluation so there remains some gaps.
19 https://news.un.org/en/story/2020/08/1070152
20 Ibid.

337
Focus Group Discussion

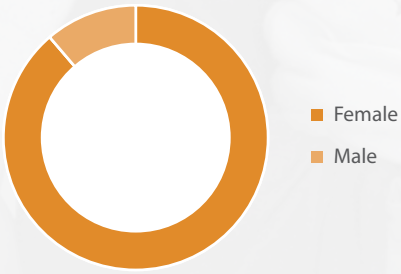
FGD Participant Numbers by Country and Facility Type



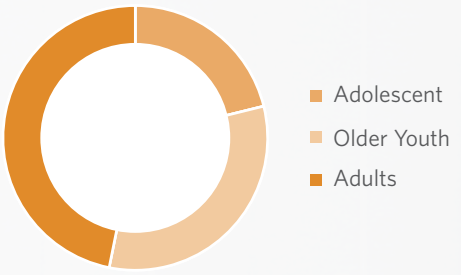
FGD Participants by Facility Type



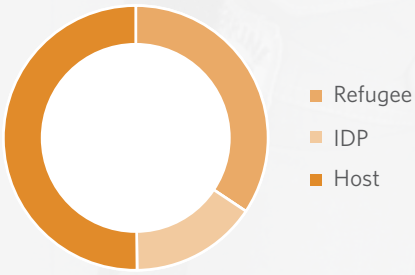
FGD Participants by Gender

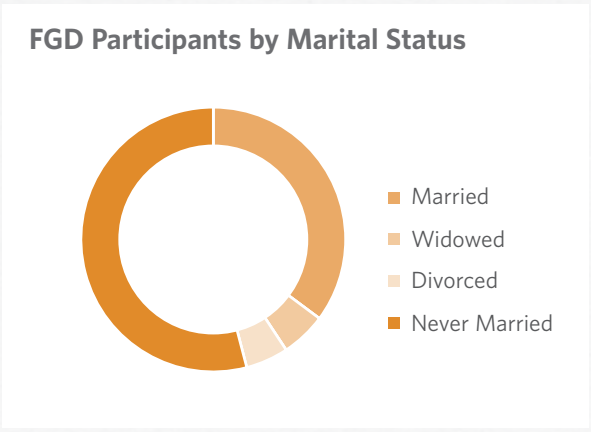


FGD Participants by Age



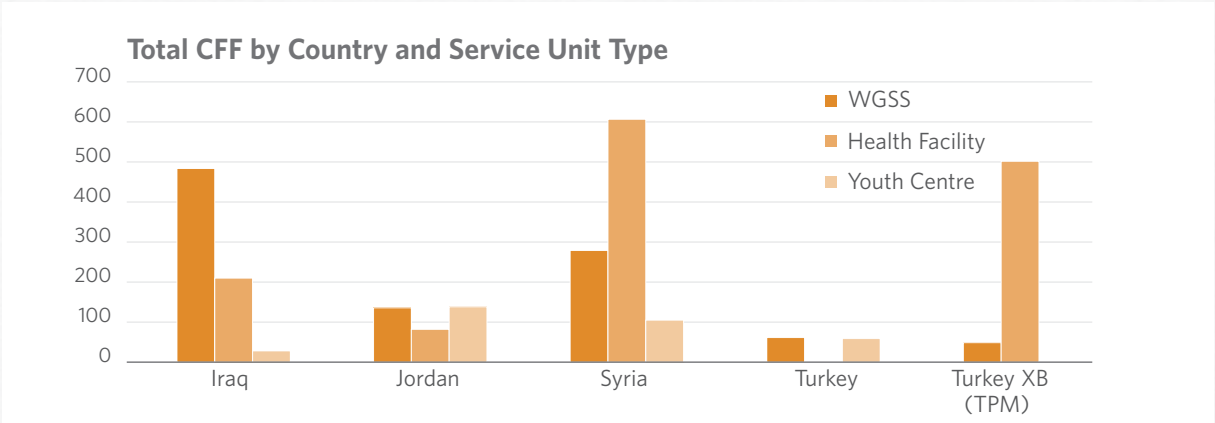
FGD Participants by Residency Status

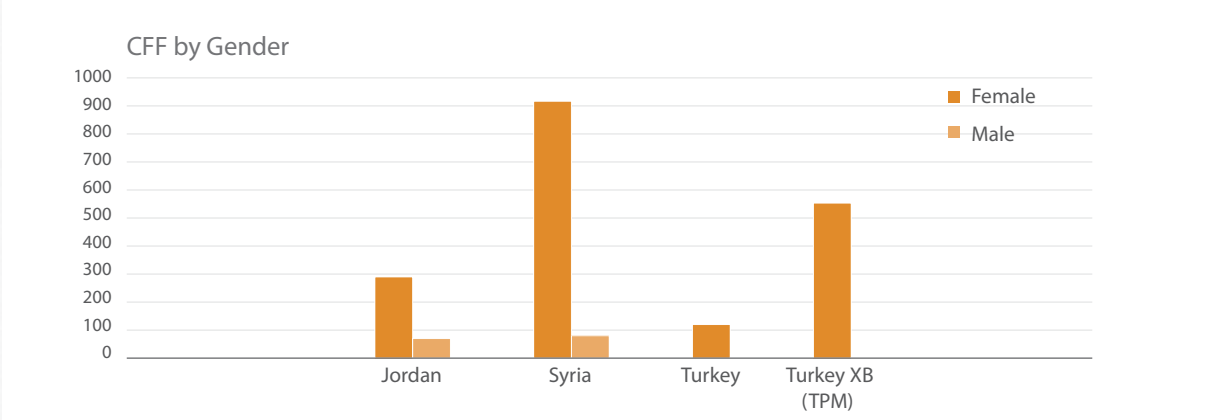


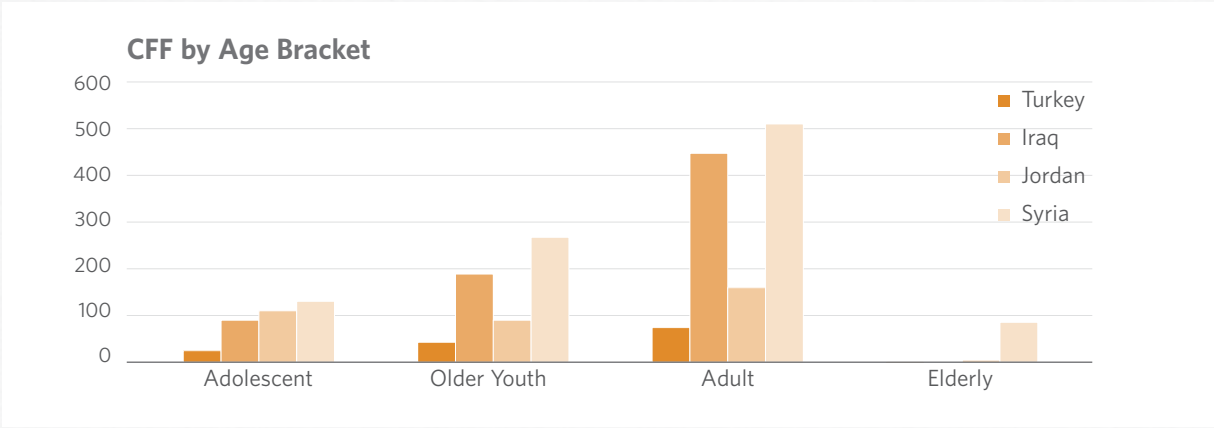


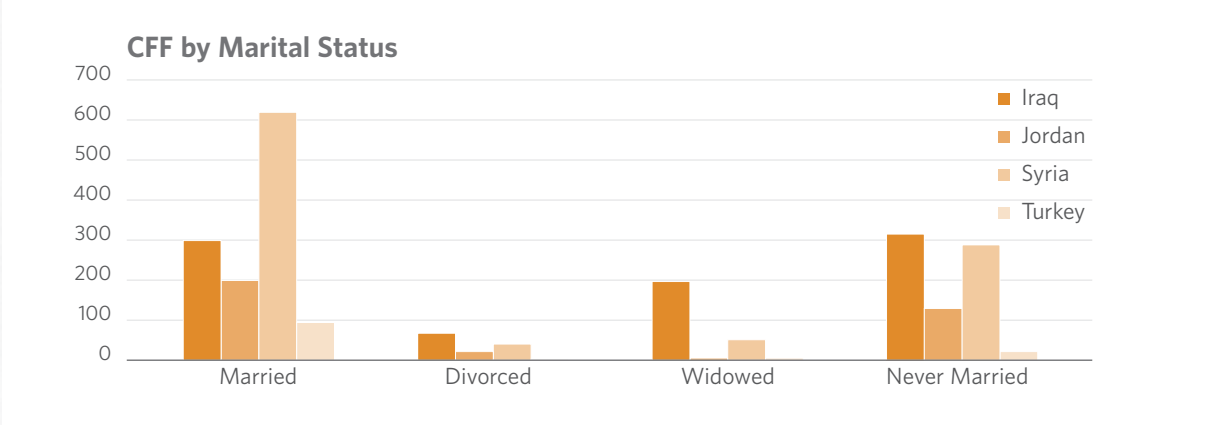
Out of the 51 FGDs conducted, 6 were conducted specifically with People with Disabilities – 5 in Syria and 1 in Turkey; 6 were conducted specifically with adolescent girls (2 in Syria, 2 in Turkey, 1 in Jordan, and 1 in cross-border Turkey operations) and 1 was conducted with older women (cross-border Turkey operations).

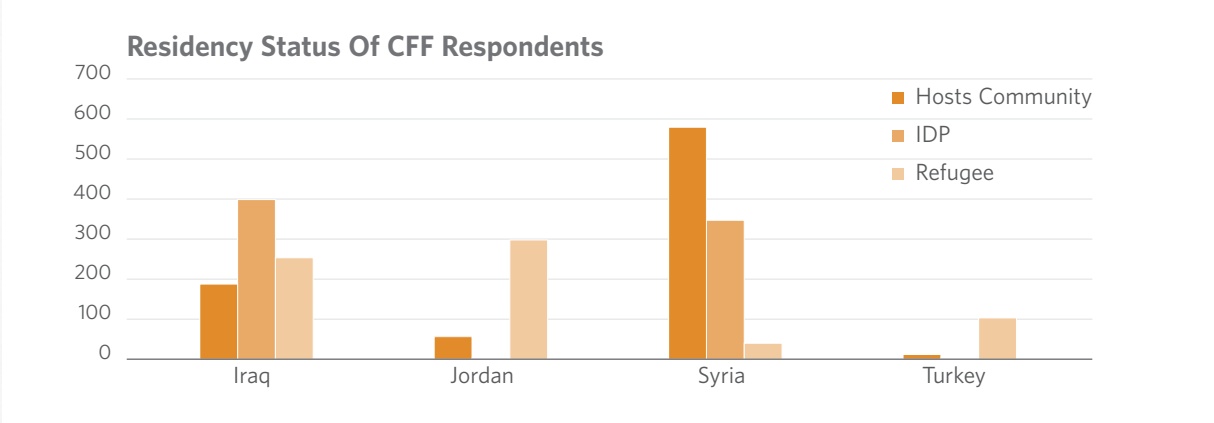
2754
Client Feedback Forms

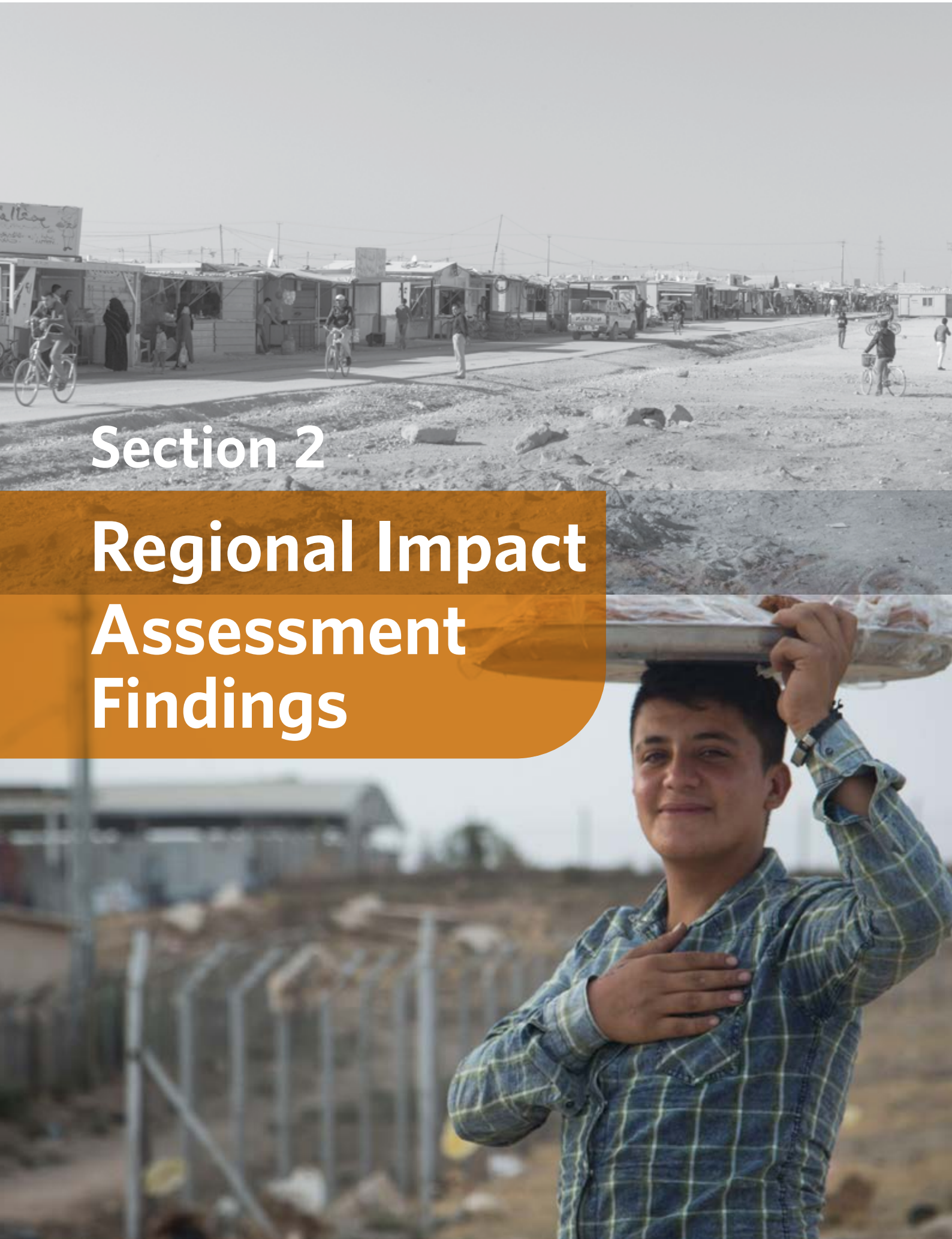





CFF by Age Bracket
600
500
400
300
200
100
0
Adolescent
Older Youth
Adult
Elderly
Turkey
Iraq
Jordan
Syria


CFF by Marital Status
700
600
500
400
300
200
100
0
Married
Divorced
Widowed
Never Married
Iraq
Jordan
Syria
Turkey


Residency Status Of CFF Respondents
700
600
500
400
300
200
100
0
Iraq
Jordan
Syria
Turkey
Hosts Community
IDP
Refugee



Section 2

Regional Impact Assessment Findings

Section 2. Regional Impact Assessment Findings

2.1 Improved physical and psychosocial wellbeing

This dimension included the following questions which were asked as applicable through KIIs, FGDs and / or CFF.

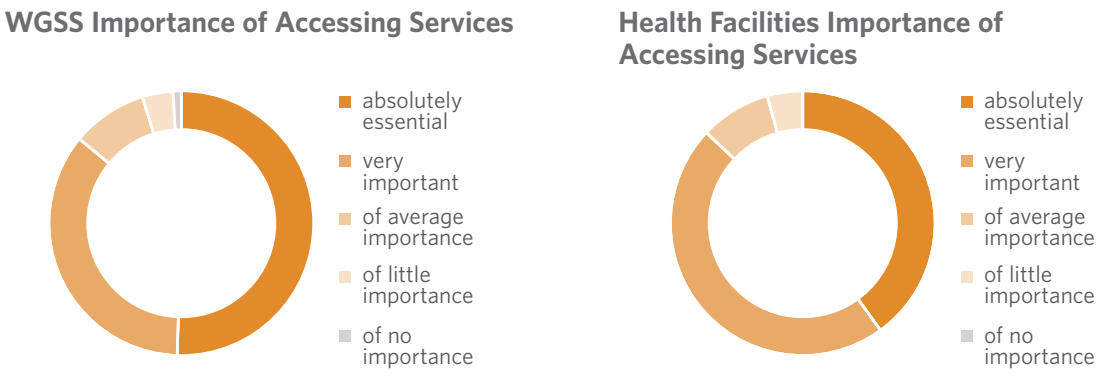
1. What services and/or activities are provided at this facility? How are these services decided upon? 2. Overall, do you feel that that this centre makes your life better in some way, and if so, how? 3. What would you improve or change? 4. Why do you come here? 5. Which activities / services have you been participating in so far? 6. What are the two most important activities / services for you? 7. What is the most important thing you have learned here, and why? 8. How important is it for you to have received this service today? 9. If UNFPA were to incorporate cash and voucher assistance into programming, what are the potential challenges and what would be the main benefit? (Note, for Turkey cross-border only: Where cash assistance is provided, what is the contribution to women and girls' wellbeing? what are the challenges? 10. Have you or other women and girls (or youth) stopped using this centre due to covid-19? What impact has that had on you / them? 11. Do you feel safe in this centre? 12. Do you feel respected in this centre?

This information below is collated across all countries to summarise the *IMPACT* of UNFPA services within the Syria regional response programme.[21] This section of the report is divided into five components:

Impact of WGSS; Impact of health facilities; Impact of youth centres; Impact of cash assistance; Impact of COVID-19;

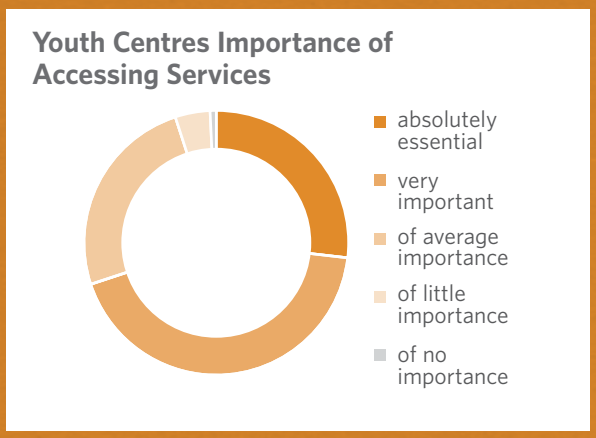
The impact of all services is high, as reported by beneficiaries themselves. Importance of accessing services, as self-reported by beneficiaries through CFFs, is depicted below:[22]

Figure 4. Importance of accessing services in total



21 Iraq did not conduct any FGDs so the information is less rich, taken from generic CFFs, than for other countries. Turkey cross-border did not distribute any CFFs as there is a third party monitoring (TPM) mechanism in place to regularly collect similar information. Consolidated TPM reports were used to extract data into the CFF format as much as possible, but the data is not as in-depth as the CFF nor available for full analysis as it is already aggregated. Turkey cross-border only conducted three FGDs.

22 Note that (a) there is no collatable information from Turkey cross-border as no CFFs were distributed and information was extracted from TPMs which did not align with the data for other countries for this component; (b) there is no health facility data for Turkey as there is no health component to the programme.



The most satisfied beneficiaries across all countries were WGSS beneficiaries, with 51% reporting that accessing services through the WGSS was "absolutely essential" to their wellbeing. A further 36% reported it being "very important".

An exactly equal number of health facility beneficiaries reported impact in the top two satisfaction surveys (absolutely essential and very important) together compared with the WGSS beneficiaries so a total of 87%. There was less reporting that services were absolutely essential (40%) and significantly more (47%) reporting that services were very important.

For youth centres, nearly three quarters of beneficiaries reported that services were either absolutely essential or very important (69%) but with a smaller proportion of beneficiaries (27%) reporting that services were absolutely essential. One in four youth (25%) reported that services were only of average importance compared to less than one in ten for both WGSS and health facilities (9% each).

This is critical information: **WGSS provide absolutely essential life-saving, highly critical services.** More women and girls reported access to WGSS being absolutely essential than access to health facilities (with medical service provision). While it is clear that historically, WGSS have been seen broadly within the humanitarian community as a 'nice to have but not necessary to have' this information clearly highlights the impact on physical and psychosocial wellbeing that access to WGSS has for women and girls, and therefore should be considered an essential life-saving service.

> *"Psychosocial support services through lectures are vital because they help us to get information and provide us with new experiences and skills that we have not gained before, especially in dealing with our children and husbands and in providing care to ourselves and help us to relieve the stresses of daily life and feel confident and strong and able to make decisions in a safe and conscious way and get out of the circle of isolation and depression."* [23]

> *'Expanding my imagination and I got to know myself and I changed 180 degrees and my thinking and awareness changed – I was encouraged to finish my education and I finished the 9th grade and I will finish my high school diploma because this space encouraged me.'* [24]

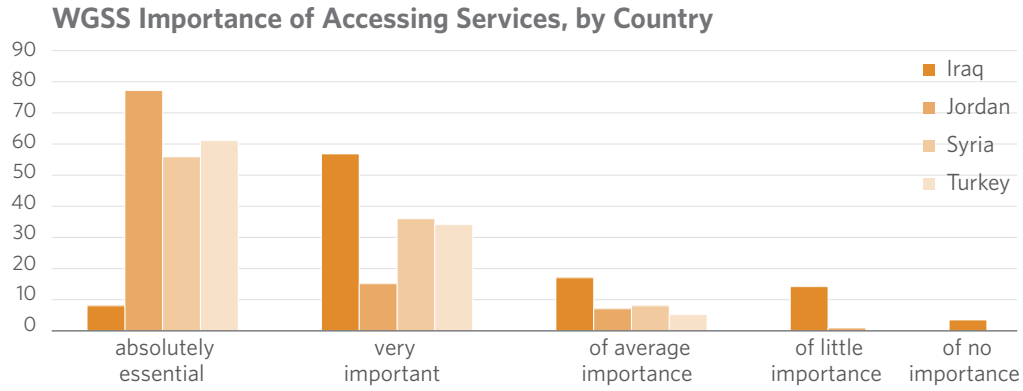
> *"My husband does not allow me to leave the house except to go to the centre."*[25]

> *"We have learned about laws and our rights. I was on the verge of divorce with my husband. I could not communicate with him and suffered extreme violence [sad and weeping]. My children would witness violence. I was ashamed. I was living as if all those things that society taught me were my fault. I was dependent on my husband and I could not even move without getting his permission. After participating in these activities, I understood that I am an individual. I learned my rights and realised my power. I have stopped my husband when he attempted to hit me. Now, I do not ask for permission to leave home or do something but I just go and do it. I feel like the President of Turkey."*[26]

23 Jordan WGSS female FGD participant.
24 Syria WGSS female FGD participant.
25 Turkey cross-border WGSS elderly woman FGD participant.
26 Turkey WGSS female FGD participant.

Women and Girl Safe Spaces

Figure 5. Importance of accessing WGSS by country



Safe spaces for women and girls (WGSS) across all countries within this assessment provide a range of services including case management services, referrals, counselling, psychosocial support, awareness sessions, distribution of dignity kits, vocational trainings, specific adolescent awareness and life skills courses. In Jordan there is also a hotline providing counselling for GBV survivors and more generalised PSS. In Turkey, UNFPA also used the WGSS model to provide primary health care services directly, with midwives and nurses on site. A referral system allowed women and girls to access a breadth of other services. In addition, the WGSS provide counselling, information, distribution of hygiene and dignity kits, and empowerment, vocational and education (mainly language) courses. There are also, in certain centres, access to additional services such as vaccinations and cervical screening.

WGSS FGD participants highlighted a number of important benefits of accessing WGSS, including the *"psychological comfort"* of the spaces; the change in daily routine and the alleviation of boredom; access to a diverse range of services for free; *"kind and gentle"* service providers; and friendship support. Beneficiaries all highlighted that accessing services *"lifted their spirits"* as well as developing new skills, increasing confidence, and meeting new people.

WGSS FGD participants were very keen on the sewing courses and suggested more of these courses could be run, with more sewing machines.

For Turkey cross-border operations, TPM reports highlighted that there were positive reviews in all criteria categories. All centres offered transportation services for beneficiaries who struggle to access the centres but also with priority given to people with disabilities. Both centres offer childcare services to beneficiaries and have hired full-time staff to cover childcare responsibilities. No significant negative feedback was given on access to the centre. The referral pathways, case management, and PSS services are all available and free of charge. All feedback on staff behaviour and quality of services was either considered satisfactory or very satisfactory.

Across different contexts, different ideas were suggested for improvements which included in some cases more of the same such as more sewing courses, more computer courses, more language courses (English across all countries and in addition, Turkish courses in Turkey),[27] improved (bigger) spaces, improved transport to and from the facility.[28] In addition to this, some beneficiaries in Jordan suggested that having remote (telephone-based) follow-up services would be useful.

The most requested improvement across all contexts was having more income-generating activities with linkages to employment / earning capacity and particularly having these aimed at more vulnerable individuals, such as those with disabilities. This included requests such as the provision of a sewing machine once a sewing course was completed, so it could lead to income for women and adolescent girls.

27 In Turkey, Turkish language courses are one of the most appreciated activities in WGSS.
28 More information on this is available under Section 2.2, Access.

Indeed, a 2019 UNFPA Jordan GBVIMS report indicated that of all services, livelihoods shows the largest gap, with more than 68.5% of survivors unable to access livelihood services due to unavailability and this has not significantly changed.[29] Childcare was another common request, or, where childcare is already provided, more toys in the childcare rooms.

Adolescent girls, in particular, highlighted the increase in self-confidence that came from accessing relevant activities within WGSS (in Syria) and their preference for income generating activities (particularly hairdressing), sports, handicrafts, and recreational activities.

In Turkey, girls highlighted the benefit of having pamphlets and leaflets in Arabic to read and also reported that the fact **their mothers were treated so well in the WGSS encouraged them to also attend.**

One issue that arose was that of provision of services to men and boys through the WGSS model, which occurs in Turkey. Further, in Jordan, one FGD group requested specialised services for people with disabilities, particularly men with disabilities – suggesting that there is still a confusion as to the primary and foundational purpose of a WGSS.[30] The 2018 Syria Regional Response evaluation highlighted that previously, WGSS facilities were used for a variety of male activities and that this was problematic as it no longer remains a safe space for women and girls and global evidence shows that in these cases the most vulnerable women and girls are forbidden from accessing the space by their husbands and fathers. In most societies, women and girls have limited spaces to meet, with public spaces largely inhabited by men. The purpose of a WGSS, as highlighted by global guidelines – developed by UNFPA – is to provide a space especially for women and adolescent girls. For example, even in this assessment, women reported that they only access WGSS because they are female only:

> *"We would not go to another centre because it would be mixed gender. But here we are comfortable."*[31]

> *"Yes, I feel safe, because all of them are females, they are very nice, and most importantly, I am certain of complete confidentiality in the centre without any fear that my story would be told to other people."*[32]

> *"My husband trusts where I am going and he trusts the centre, but he wouldn't trust any other place."*[33]

> *"My husband does not allow me to leave the house except to go to the centre."*[34]

In Turkey, some UNFPA partners report that WGSS are also used to provide GBV awareness sessions to men. While both male and female beneficiaries reported this as positive, again, WGSS facilities being used for male activities is problematic and against global guidelines – developed by UNFPA – for WGSS.[35] Male WGSS FGD participants reported the benefit of attending awareness sessions at the WGSS, regarding child marriage and gender discrimination.

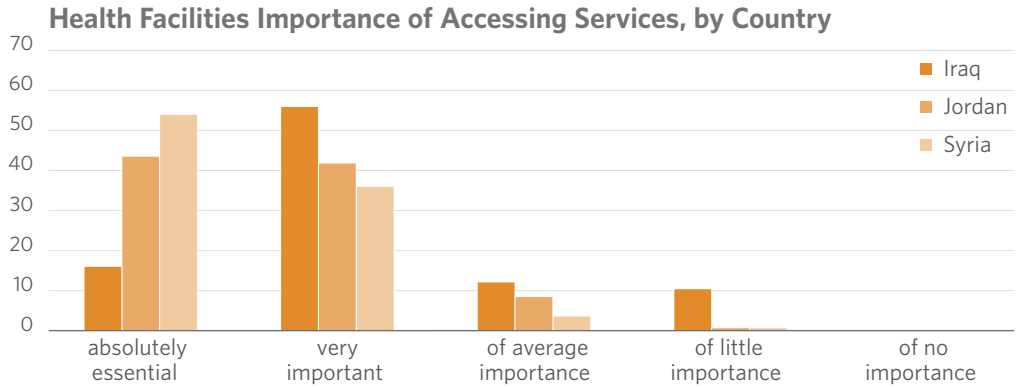
Women with disabilities in Turkey highlighted the benefits of attending sessions, with reference to being treated with compassion and value, and feeling accepted and strong.

29 UNFPA. Jordan GBV IMS Task Force Annual Report. 2019.
30 JCO confirms no male activities are conducted in WGSS.
31 Syria WGSS female FGD participant.
32 Jordan WGSS female FGD participant.
33 Syria WGSS female FGD participant.
34 Turkey cross-border WGSS elderly woman FGD participant.
35 The issue of WGSS being preserved for women and girls only is referenced in the UNFPA own guidance note on WGSS – https://www.unfpa.org/sites/default/files/resource-pdf/UNFPA%20UNFPA%20Women%20and%20Girls%20Safe%20Spaces%20Guidance%20%5B1%5D.pdf; and also in the Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming - https://www.unfpa.org/sites/default/files/pub-pdf/19-200_Minimun_Standards_Report_ENGLISH-Nov.FINAL_.pdf; and also in the latest IRC/IMC WGSS toolkit - https://reliefweb.int/sites/reliefweb.int/files/resources/IRC-WGSS-Toolkit-Eng.pdf

The fact that women ask for activities for their husbands or male relatives highlights the confidence that women have in UNFPA's support and ability to challenge norms and certainly is an idea worth pursuing but only within the parameters of understanding that WGSS themselves should not be used for male awareness raising activities and furthermore, it is unlikely that a short course of awareness raising sessions would significantly alter embedded male behaviour within the homes. However, again it is a sign of confidence in UNFPA and partners that women are requesting interventions targeting their husbands.

Health Facilities

Figure 6. Importance of accessing health facilities by country



Across the Syria regional response, UNFPA provides a variety of standalone and integrated SRH facilities from midwives and nurses in WGSS settings providing family planning and counselling, through to comprehensive emergency obstetrics care and everything in between.

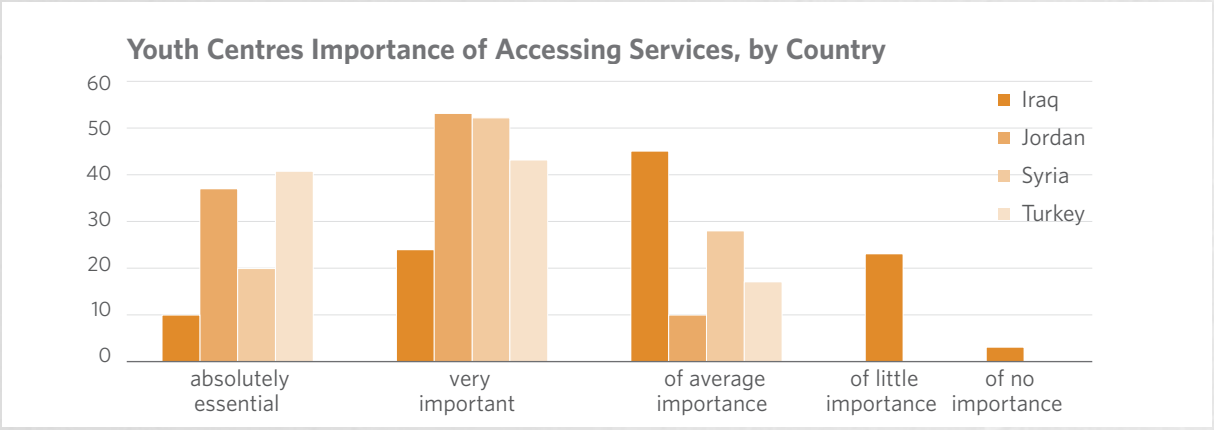
While FGD participants suggested many recommendations for improvements, not all of these fall entirely within the mandate of UNFPA. So, for example, in Jordan health clinic beneficiaries suggested a list of services they were keen to receive – paediatric therapy, dental treatment, treatment for diabetes, and treatment for hypertension for men – of course none of which are SRHR services. This does highlight the types of additional medical services beneficiaries are requiring but UNFPA should always be cognisant of the fact that there are other organisations – such as UNHCR and WHO – with a responsibility for broader health services.

A common request across all countries was for free hand sanitiser since the pandemic started. For all countries, women reported that family planning services and antenatal care are prioritised as the two most important services for them to access and that these are critical to the wellbeing of women and girls. There was limited additional data on the *impact* of health services from this assessment, although much richer data with regard to the *accessibility* of health services.[36]

36 Noting that there were just two FGDs conducted in health facilities, both in Jordan, and the participants agreed with the importance of services but provided limited additional data on this, with much richer information being provided on accessibility questions.

Youth centres[37]

Figure 7. Importance of accessing youth centres by country



"The centre is giving us something positive, and we are spreading this positivity around."[38]

UNFPA operates youth centres to differing degrees across all Syria regional response contexts with the exception of cross-border Turkey operations which focus on WGSS and health facilities.

The youth centres that are operational (four in Iraq, one in Za'atari camp in Jordan – and additional support to youth networks, nine in Syria, and four in Turkey) provide a range of social, cultural, sporting, recreational, educational and vocational activities. Iraq and Jordan also focus on peace-building skills, with Iraq having worked to build the capacity of 268 youth on mediation skills and a total of 7,229 youth participated in prevention of violence and extremism (PVE) activities.[39] UNFPA Jordan, through their implementing partner for the youth centre in Za'atari, Questscope, run a 'best of life' programme which builds youth capacities in a variety of areas and a community outreach programme, training youth on community communication methodologies. There is also a mentorship programme. In addition, there are a variety of sport and art and craft activities, language and computer lessons, and a full library.

Youth centre FGD participants across all countries requested more sports activities and more formalised education classes with official certificates. English language (and in Turkey, Turkish language) courses are a common request, as are computer courses and internet access. For youth in youth centres, participants reported a wide range of activities as being favourites – sport, the library, learning English, computer courses, music, and art.

Youth described the benefits of self-development, feeling more self-confident and specifically the enjoyment of civic engagement and giving back to their communities. **This is important: youth centres are not just about benefiting youth but facilitating what youth can give back to their communities.** This aspect of youth engagement is clearly highlighted in the Compact for Young People in Humanitarian Action guidelines.[40] Youth say that accessing the centre boosts their relationships, their knowledge, their social interaction, and their confidence to speak about problems and solutions.

Age is a potential issue with youth centres. The youth centre in Za'atari camp in Jordan targets young people aged 12-30. In Turkey, youth centres target age ranges of 15-30 although one partner reported targeting adults up to the age of 35. Global guidelines for working with and for young people in humanitarian contexts (currently in the process of being endorsed by the Inter-Agency Standing

37 Not that youth centre FGDs were not always gender-disaggregated and key informants did not provide any gender-disaggregated information. CFF gender disaggregation did not highlight any particular differences and without complimenting substantial qualitative evidence from FGDs and KIIs it is quite meaningless. The Assessment Team suggests this is considered for next year and while youth are often happy to participate in mixed FGDs, if UNFPA require gender-disaggregated information then the FGDs should be arranged accordingly.
38 Syria Youth centre FGD participant.
39 This data is not gender-disaggregated.
40 Global guidelines for working with and for young people in humanitarian contexts (currently in the process of being endorsed by IASC and developed under the Compact for Young People in Humanitarian Action, for which UNFPA is a lead)

Committee (IASC) and developed under the Compact for Young People in Humanitarian Action, for which UNFPA is a lead) confirm the globally agreed age ranges of:

10-19 being **adolescents;**

15-24 being **youth**; and

10-24 encompassing both groups and termed **'young people'**.

It is important to consider, when opening youth centres to older adults (a) how much this denies services to UNFPA target audience of adolescent girls, particularly when there are 30 year old married men in the centre so many girls will be unable to be within that same space; (b) how this aligns with the UNFPA mandate and target constituency and (c) what is the duplication of services when married adult women are accessing services through a youth centre rather than a WGSS and why are they accessing youth services rather than WGSS services as adult married women.

Notwithstanding community requests and national guidelines (with recognition that the Compact guidelines do reference national policy), it is incumbent upon UNFPA to balance global good practice and UNFPA mandate constituency audiences with community demands and to ensure that targeted adolescent demographics are not unintentionally excluded based on services being provided to older male and female demographics.

Safety and Respect

Across all countries, beneficiaries of all services, through both FGD and CFFs, reported feeling safe and respected in UNFPA-supported facilities and centres, with few exceptions.

> *"The safest place I have ever felt has been the facility."*[41]

In Iraq, 2 out of 484 WGSS beneficiaries stated they did not feel safe (no further comments given, response through CFF) and the same two highlighted they did not feel respected. All health facility and youth centre beneficiaries reported feeling safe and respected. In Jordan, one health CFF response out of 82 reported feeling unsafe and two reported not feeling respected.

For youth, two out of 140 youth centre CFF responses reported feeling unsafe, with no-one reporting a lack of respect. For women and girls accessing services at WGSS, one out of 137 CFF responses reported feeling neither safe nor respected.

In Syria, all WGSS CFF respondents reported feeling safe with two out of 280 reporting not being respected. For health facilities, 2 out of 608 CFF respondents reported not feeling safe and 4 reported not feeling respected. All youth centre CFF respondents (107) reported feeling both safe and respected.

41 Turkey WGSS female FGD participant.

> **UNFPA have a new cash and voucher specialist within the Humanitarian Office and this is an area of work UNFPA will be scaling up in the future.**

In Turkey, all WGSS and youth centre FGD participants felt both safe and respected in the centres. For Turkey cross-border operations, all FGD participants (all WGSS FGDs) confirmed that they felt safe and some specifically highlighted the fact that they feel safe because there are no men there, which is important as it reinforces the global standards of keeping WGSS female-only. All FGD participants confirmed that they were respected (and "valued") in the WGSS.

Cash Assistance

Across the UNFPA Syria regional response countries, at the time of the assessment, cash assistance was currently only used in the Turkey cross-border response for individual protection assistance and case management. Syria was in the process of establishing a large cash and voucher assistance (CVA) programme with WFP and Jordan had also started some cash programming. This assessment looked at the benefits and challenges of the existing Turkey cross-border cash programming, and within the other countries, collected data on what the potential benefits and challenges of introducing cash might be. UNFPA have a new cash and voucher specialist within the Humanitarian Office and this is an area of work UNFPA will be scaling up in the future.

Turkey cross-border operations do currently provide protection cash assistance to selected beneficiaries. A needs assessment conducted by REACH[42] in April this year identified that 81% of assessed IDPs reportedly faced problems in obtaining humanitarian assistance with 91% stating that 'not enough' assistance was available for all in need. Among the most vulnerable and at-risk groups among newly displaced groups were reported to be, inter alia, female-headed households and persons with disabilities.

UNFPA provided, through four Implementing Partners (IP), a one-off unconditional Individual Protection Assistance (IPA) programme. The programme was distributed between April–July 2020 in the form of cash or vouchers to approximately 8,192 persons (51% female and 49% male). As per Cash Working Group calculation of the Survival Minimum Expenditure Basket, an approximate total of 100-120USD was given to each beneficiary.

42 REACH is a leading humanitarian initiative providing granular data, timely information and in-depth analysis from contexts of crisis, disaster and displacement. The work of REACH directly feeds into aid response and decision-making by providing accessible and precise information on the humanitarian situation of crisis-affected populations.
Created in 2010, REACH is a joint initiative of IMPACT Initiatives, ACTED and the United Nations Operational Satellite Applications Programme (UNOSAT). REACH activities are conducted in support and within the framework of inter-agency coordination mechanisms at field and global levels to enabling more efficient aid planning and response. https://www.reach-initiative.org/who-we-are/

The main beneficiary criteria were IDPs displaced after December 2019. Other key shared vulnerability criteria included: woman-headed households; elderly-headed households; households with persons with disabilities; newly arrived displaced persons without shelter; high-risk pregnant or lactating women without family support; severe medical conditions; extreme poverty; and GBV survivors and women and girls at risk of GBV.

Overall, the IPA project was considered relevant and effective as transactional costs have been minimal and beneficiaries have been given full agency to determine what his/her immediate needs were. Subsequently, IPs reported positive protection outcomes for beneficiaries (although no specific examples were provided) and expressed the need for such IPA projects to continue given the prevailing and persisting protection needs on the ground among people in northwest Syria. Recommendations focused on continuing with the IPA project and considering expanding beneficiary criteria to include vulnerable hosts community members and to ensure adequate safety measures during implementation and find ways to mitigate male dominance within the household over cash expenditure.[43] This is extremely important to have established for cash programming to ensure that the programme is not creating more harm for women within their households.

All respondents to this assessment agreed that the IPA was extremely impactful. They proposed allocating more cash and adopting a wider criteria range to capture more vulnerable women and girls.

UNFPA Jordan has already started considering voucher assistance, with a consultant currently advising on next steps. The Jordan CO staff believe cash to be a good practice model for UNFPA globally – in the right contexts – to facilitate access to services.

In Jordan, there is significant cash programming by other actors but not necessarily linked to GBV case management as UNFPA would do. This is perhaps one of the value adds for UNFPA-specific cash assistance.

There was also a sense that cash becomes even more important for accessing services during COVID-19 with successive lockdowns where women and girls are often referred to different services that remain open, but some of which might not be free.

In Syria, UNFPA started an e-voucher programme in 2014 for RH services, which was terminated but recently revived with positive impacts The Syria UNFPA country office is currently planning for an expansion after a successful 2020 pilot programme. This revived programme works by piggybacking on the WFP cash voucher scheme, whereby it adds an extra $10 for hygiene items specifically for pregnant and lactating women (PLW), with an initial target of reaching 70,000 PLW across Syria.

UNFPA and partner staff all report great hopes for the e-voucher programme highlighting the significant benefits of specifically addressing the issue of poverty for women, although a challenge agreed by most respondents is still the correct targeting. Because there is no interagency cash system in Syria there is a reliance on WFP, and this is somewhat limiting in terms of:

- it is limited to PLW only;
- it is limited to types and amounts of hygiene items – UNFPA has been advocating to WFP for more flexibility in terms of procurement of hygiene items, but WFP (possibly understandably) do not want to provide more flexible hygiene items over food items;
- the additional e-voucher cost is limited to approximately $11;

In Turkey, UNFPA and partners do see some potential benefits of cash for certain populations, particularly youth where youth unemployment is high or there is a high prevalence of dangerous and low paid jobs. Cash assistance would provide a buffer to allow them to access services. There is still a sense in Turkey among some partners and stakeholders that cash assistance immediately following an emergency is problematic in that it will lead people to "become lazy", but generally UNFPA staff themselves have a deeper understanding of the benefits of cash. However, in Turkey there is a national cash assistance programme – the Emergency Social Safety Net (ESSN) programme funded by ECHO with limited authority to start any other parallel programme. The ESSN has certain eligibility criteria and even for that there is now increasing debate in Turkey about what an exit strategy looks like – given that the Syrian refugee crisis is coming up to a decade old.

43 UNFPA internal document. UNFPA-supported individual protection assistance project Northwest Syria – Lessons Learned.

The question for UNFPA Turkey is one of role and mandate, and how to add value to overall cash assistance. So, for example, UNFPA Turkey support a key refugee group (KRG) project (funded by DG ECHO), which includes key population groups — LGBTI individuals, sex workers, and people living with HIV (PLHIV) — that are not eligible for enrolment in the cash programme, based on their status. UNHCR run a cash programme specifically for trans and intersex individuals, but this is limited in both scale and scope. The EU-funded Emergency Social Safety Net (ESSN) is primarily based around shelter and food, and not hygiene – so for women and girls, this would certainly be an area where the UNFPA can add value with the provision of niche services.[44]

COVID-19

Some overall common themes across all countries include:

- increasing reports of domestic violence across all countries;
- women and girls have continued to highlight throughout the pandemic how critical WGSS services are for their wellbeing;
- youth are more able to access online activities, but also severely impacted by increased unemployment and reduced income-generating activities;
- younger women and adolescent girls are more willing to continue accessing WGSS services – i.e. having less fear of catching COVID-19 – as long as mitigation measures are in place;
- there are certain modalities that UNFPA and partners were forced to adopt for COVID-19, which may be useful to continue after the pandemic to compliment the more traditional face-to-face engagement with beneficiaries, which include hotlines, online counselling and expanded mobile outreach.[45]

Various challenges – and some potential lessons learned for changing modalities in the future – were discussed during the assessment, specifically vis à vis the global COVID-19 pandemic. Many challenges were common across all countries, but specifically highlighted by respondents in particular countries. In Iraq, respondents reported that the process of referrals to further health and protection services became extremely challenging. The Ministry of Health (MoH) prioritised the response to COVID-19 which impacted on already-stretched SRH services. Added to that, social distancing, curfews, restricted movement and general fear impacted lives and increased risk of GBV (particularly domestic violence) and simultaneously reduced access to services and assistance.

UNFPA reported that it was easier to adapt for GBV where some services and support could be provided virtually, than for RH services where women and girls needed to be physically present. Safe spaces for women provided remote services until work resumed in the centres, because there was an urgent need for GBV case management services with the increase in violence within families. For camp-based populations, there was increased difficulty in reaching services where curfews were strictly enforced. Service providers report that for non-camp refugees, communication was easier through telephone and social media. In-person WGSS services only stopped for a very short period. When services re-opened, they did so with smaller numbers of women and girls accessing the safe spaces.

Youth centres closed during lockdown and youth faced many difficulties, particularly in camps where the centres are the only recreational and educational place. While activities and training were offered online, those inevitably did not reach all youth. During the lockdown, Questscope and the Syrian volunteers created 17 WhatsApp groups to maintain the conversation and services around youth wellbeing, mentorship and sharing health-related information – in addition to "sports at home", art creation and self-development messages. Questscope procured 53 computer tablets, creating a "lending system" for youth beneficiaries to access the devices and data bundles. All of the UNFPA-supported incentive-based volunteers (IBVs) who provide youth services, were equipped with Zoom subscriptions for conducting virtual peer workshops and meetings.

In Jordan, it was highlighted how much everyone in the community – women, girls, men and boys across all age groups - were feeling greater stress and anxiety due to both the pandemic *and* the strict government lockdown response to the situation.[46] The FGDs conducted for this assessment highlight

44 There was no information provided about views on cash programming in Iraq.
45 UNFPA has released a best practices and lessons learned for COVID-19 special knowledge series publication which highlights some of these issues: https://syria.unfpa.org/sites/default/files/pub-pdf/covid-19_best_practices_-_english_-_141020-2_0.pdf
46 UNFPA. Daring to ask, listen and act: a snapshot of the impacts of COVID on women's and girl's rights and sexual and reproductive health. 2020. https://jordan.unfpa.org/en/resources/daring-ask-listen-and-act-snapshot-impacts-covid-womens-and-girls-rights-and-sexual-and

that a number of youth stopped using youth centres during the pandemic, but many youth activities were able to be converted to online platforms. WGSS services tried to provide as many services remotely as possible during the lockdown period. However, this did not stop COVID-19 adversely affecting WGSS beneficiaries in many ways. Despite the increase in domestic violence, the government temporarily closed the Ministry of Social Development shelter, while for other shelters, anyone working there had restricted movement based on government regulations. WGSS service providers report that women returned to the centre as soon as lockdown was lifted.

As reported by the Syria country office, in Syria there has been an observable increase of GBV, particularly domestic violence, due to the COVID-19 pandemic – blamed specifically on both the containment measures and the worsening economic situation. Families were restricted in their homes, with many men being daily workers and unable to earn money. The combination of the two issues – increased frustration and physical lockdown – exacerbated risks of violence. UNFPA conducted a series of webinars on remote service provision, which, while useful, have not been able to solve all challenges. For example, UNFPA reports that problems still remain with disclosure over the phone,[47] with so many women having built up a significant level of trust through face-to-face time in WGSS and so understandably struggling with telephone modalities instead. Referrals of GBV survivors became problematic in many places, as many service points were closed.

In contrast, youth reported easily being able to access their courses (such as English language courses) online but missed some of the theatre and sports activities they were used to participating in. UNFPA Syria reported that many of their health facilities actually saw an increase in beneficiaries, because other service points had temporarily closed, while other facilities saw a slight decrease.

On a more positive note, UNFPA Syria is trialling the production of face masks in the WGSS to distribute to service centres. In addition, UNFPA reports that there were a number of new and creative initiatives implemented because of the pandemic, and some of them are helpful, such as remote training, WhatsApp groups, Facebook pages for information etc. It allows for providing alternative channels to reach people and there is a sense that maybe these channels can remain in addition to the more traditional ways of working when the pandemic is over.

In Turkey, it was clearly highlighted how the more vulnerable and disadvantaged groups were most impacted by COVID-19, including a rise in domestic violence. Generally, UNFPA and partners are receiving more requests regarding basic needs, such as concerns over losing homes through not paying rent (having lost income and employment due to the pandemic), and not having electricity or food. In that respect, there has been a significant increase in requests for cash assistance.

On a positive note, one unforeseen benefit to changing modalities due to the pandemic was, as reported by UNFPA, a more holistic way of reaching whole families via telephone or online platforms such as Skype. They have reported that awareness raising sessions conducted online are often attended by the whole family and they feel that in this respect, husbands and fathers are learning something, incrementally contributing to behaviour change.

47 This was the same in Jordan, where women did not have a 'safe place' in their home to call the hotlines that were set up.

Again, for youth, even though the physical centres closed, youth were mainly able to access activities which continued online. Online works better for youth than for older age groups, although not necessarily for adolescent girls with no access to their own phones. However, UNFPA partners report a dramatic increase in unemployment among young people and subsequently increased psychosocial stress with counsellors reporting more youth speaking about suicide than before. While there was a decrease in the number of women who accessed WGSS throughout the pandemic, adolescent girls in particular reported continuing to access as they felt safe as long as there were mitigation measures in place (social distancing, wearing masks, hand sanitising) and they did not want to be alone at home.

For Turkey cross-border operations, UNFPA staff report a particular impact of COVID-19 on their programme was the disruption to the planned focus on older women. Syria itself is now in a containment stage of the pandemic and, for UNFPA and partners, this means that all is operating close to normal but only with certain mitigation measures: social distancing, hand sanitising, and mask wearing. For health facility beneficiaries, online and telephone consultations were put in place where possible during the lockdown period. This was very new to north Syria and there was a lot of initial resistance – but this has since eased.

2.2 Access

This dimension included the following questions which were asked as applicable through KIIs, FGDs and / or CFF.

1. What would people do if this facility did not exist and they needed these services? Are there other places with similar services / activities? 2. How do you describe the accessibility to this facility? 3. What challenges do you face accessing the facility? 4. How did you find out about the service? 5. Are the opening hours of the facility convenient? 6. Do you think the services / activities in this centre help the women and girls / youth in your community that need the most help and that are the most vulnerable? – If not, who are the most vulnerable and why not? 7. Have you provided services to people with disabilities in the past month? [note there is a list of different disabilities] 8. How difficult has it been for you / clients to continue using services during COVID-19 times? 9. Are there other women / girls / youth who have stopped using the services in this facility because of COVID-19? What has the impact on them been? 10. How have you adapted services / activities for COVID-19? Do you think there are more ways that the services should be adapted?

This information below is collated across all countries to summarise the ***accessibility*** of UNFPA services within the Syria regional response programme.[48] This section of the report is divided into five components:

General accessibility of WGSS;

General accessibility for health facilities;

General accessibility for youth centres;

Reaching the most vulnerable – assessment across all service units

COVID-19; effect on accessibility and UNFPA and partners adaptation measures – assessment across all service units.

48 Iraq did not conduct any FGDs so the information is less rich, taken from generic CFFs, than for other countries. Turkey cross-border did not distribute any CFFs as there is a third party monitoring (TPM) mechanism in place to regularly collect similar information. Consolidated TPM reports were used to extract data into the CFF format as much as possible, but the data is not as in-depth as the CFF nor available for full analysis as it is already aggregated. Turkey cross-border only conducted three FGDs.

Women and Girls Safe Spaces

With regard to WGSS, across all countries there is a common theme of UNFPA-supported WGSS providing quite unique services.

In Iraq, over a third of WGSS beneficiaries (36%) either do not know of other services, or state explicitly that there are no other similar services around.

For cross-border Turkey operations, multiple different third-party monitored (TPM) reports consistently highlighted the fact the UNFPA WGSS model is usually the only safe space for women and girls providing the range of services at the centre. This is confirmed by both UNFPA staff and partner staff interviews, with many reporting that UNFPA-supported services are actually the only GBV services at all in any particular location. FGD participants unanimously supported this. UNFPA is currently the only agency that provides dignity kits.[49]

For refugees in Turkey, there are other services and indeed UNFPA have transferred 30 WGSS into the Government of Turkey migrant health centres (MHC). However, Turkey WGSS staff highlight that no other centres provide the same integrated protection and health services as the WGSS model, which can provide certain aspects of the MHC, the hospital, and the Social Service Centre (SSC). It also provides counselling and then referral so it is reported that many beneficiaries prefer to access the WGSS first, before being referred.

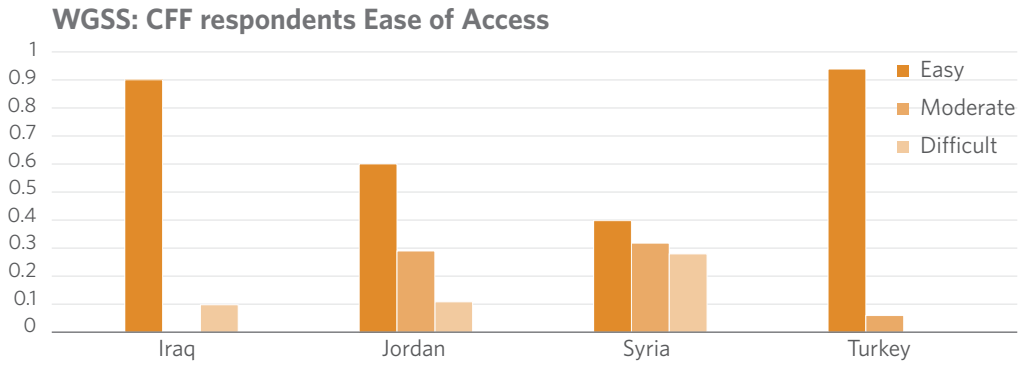
For Jordan WGSS services, staff report that there are other institutions present in the camps (Za'atari and Azraq) but not as integrated as the WGSS model with SRHR services, GBV case management, PSS, and educational and vocational courses for economic empowerment, together with referral services.

Outside of the camps, some beneficiaries stated there are no other similar services, but in others they noted various options.

Other UN agencies in Syria, such as UNHCR, that provide some GBV prevention and response services. Outside of the UN system many WGSS FGD participants reported that while other similar services are available, none of them are free. One FGD highlighted why it is so important to keep WGSS for women and girls only: *"We would not go to another centre because it would be mixed gender. But here we are comfortable."*[50]

In relation to ease of access to UNFPA-supported WGSS, an overwhelming majority of beneficiaries reported easy access.

Figure 8. Ease of access to WGSS



In **Iraq,** it is clear that 90% of WGSS CFF respondents report facilities being easier to access than years previous. For challenges to access, various issues have been noted by staff, previous reports, and indicated on CFF forms, including distance to facility, stigma, lack of awareness of services, and lack of awareness of facilities.[51] In Iraq, mobile teams have been put in place to try to reach geographically dispersed and displaced women and girls.[52]

49 UNFPA has cooperated with World Vision to take over dignity kit distribution if UNSCR is not renewed.
50 Syria FGD participants.
51 From both CFF responses and UNFPA. 2019 Annual Report – Iraq. 2020
52 UNFPA. 2019 Annual Report – Iraq. 2020

For **Turkey cross-border** operations[53], TPM reports highlight that overall, women and girls report easy access to facilities. The main challenges are related to transport: either lack of or cost of transport. TPM reports underline the fact that many facilities provide transport for the most vulnerable beneficiaries.[54]

Some **Jordan** WGSS FGD participants confirmed the CFF responses, as the majority report easy access to the centre, but others offered a number of challenges including weather conditions (both too cold and too hot); one highlighted that her husband did not agree with her coming; childcare issues, and lack of transportation / expensive transportation.

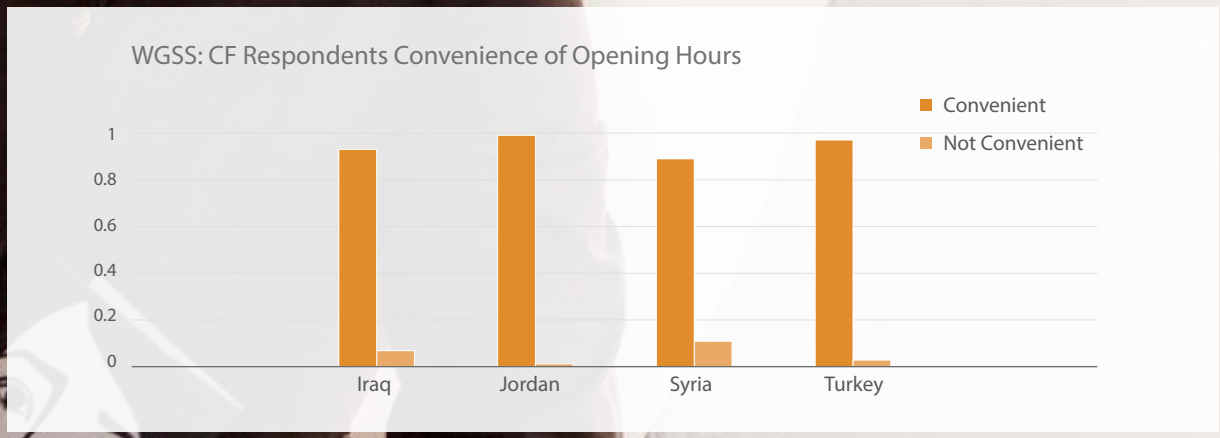
Syria WGSS FGD participants had a range of responses with regard to ease of access, mirroring the CFF responses which were split quite evenly across easy, moderate, and difficult. One reported having to take two service cabs to reach the centre which was both lengthy and costly. A respondent with disabilities reported having difficulties with transport to access the centre. Others reported easily accessing on foot or on micro buses. CFF responses mainly highlighted transport (lack of or cost of) as the main barrier to access. Girls in some WGSS FGDs and some youth highlighted a lack of free time as a barrier to access.

Almost all **Turkey** WGSS participants confirmed easy access, and no specific challenges were raised by anyone. For WGSS CFFs, a few responses vis à vis access challenges mentioned security issues, no accompanying person, and lack of childcare.

In terms of awareness of services, WGSS beneficiaries across different countries generally cite family, friends, neighbours and 'word of mouth' as the most common way of hearing about UNFPA WGSS services. In Syria, two FGD participants reported they had seen a Facebook advertisement. Other than this, referrals,[55] outreach activities, and advertising (either on social media or more traditional forms such as brochures and leaflets) do not feature highly within any country. For Turkey cross-border operations, participants in the people with disabilities FGD did highlight outreach activities as a way of hearing about services.

Almost all WGSS beneficiaries across all countries think opening hours of centres is convenient.

Figure 9. Convenience of opening hours



53 There were no CFFs distributed for Turkey cross-border operations and this information is not captured in a useable format within TPMs therefore Turkey cross-border is missing from the graph.

54 There were no CFFs completed for Turkey cross-border operations and only three FGDS and it is not possible to comprehensively ascertain if the provision of transport costs has fully reduced this barrier across the board: all FGD participants referenced receiving help with transport but the consolidation of TPM reports did not provide sufficient evidence to show this was true more broadly.

55 Note that it is possible that beneficiaries would classify a referral as 'word of mouth'.

The CFF results were confirmed by FGD participants and interviews, although some additions were provided, for example:

- In **Iraq,** WGSS staff reported many women and girls were requesting Saturday services as well.
- In **Jordan,** WGSS staff reported that during school vacations women prefer the option of having evening sessions, as do all beneficiaries during the month of Ramadan.
- In **Syria,** some female WGSS participants had challenges with childcare and some youth reported that the hours clashed with university lectures.

Health facilities

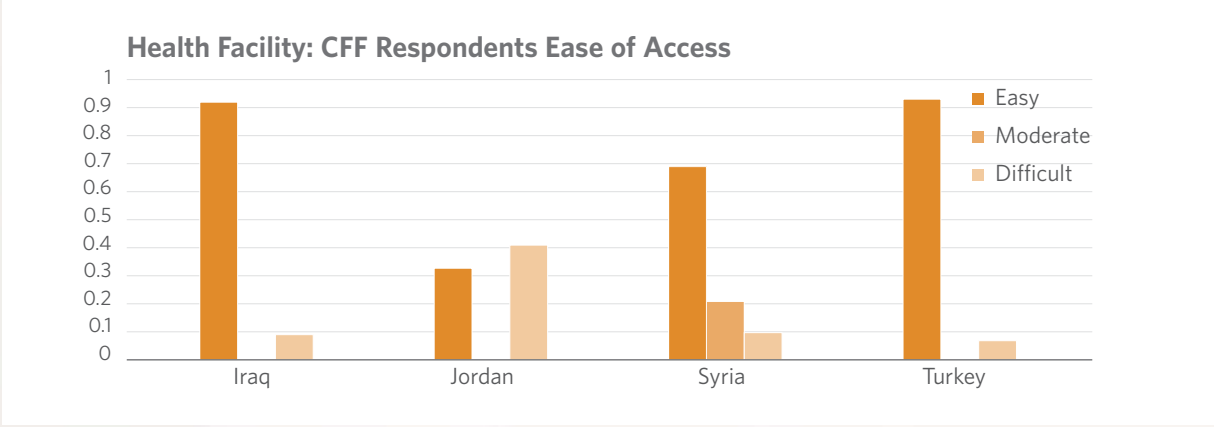
Compared to WGSS, there are many more available health services across the countries that beneficiaries can potentially access, with a **common theme being that these other services are either not free or not of the same quality as UNFPA-supported SRH services.**

In Iraq, just over 70% of CFF respondents indicated they knew of another place to access services. However, many interviewed staff reported that these services are private sector and have associated high costs. This is true also in Syria, where FGD participants and interviewees confirmed there are other services available but they are either unaffordable (private sector) or, within government centres, the bureaucracy and procedures are complicated.

For **Jordan**, Za'atari camp health facility FGD participants reported that only the UNFPA health clinic provides free *quality* SRH services, which further highlights the importance of this critical service.

For **cross-border Turkey** operations into NW Syria, the lack of Ministries, and the issues of different authorities across different lines, are a key challenge. Within one prioritisation exercise, UNFPA reported using the indicator of 'unique facility' – i.e. the only facility in the area – and within this exercise 80% of facilities were deemed essential.[56] UNFPA is the only organisation providing RH kits.

Figure 10. Ease of access to health facilities



For **Turkey cross-border** operations the challenges reported vis à vis access are the same as with WGSS, i.e. transport (either lack of or cost of transport). This was the same for Syria.

Iraq health facility CFF respondents all referenced distance only as a barrier / challenge. For **Jordan** health facilities, approximately a third of CFF respondents reported easy access. In different FGDs, the majority of participants referenced ease of access (9 out of 10 in one FGD, and 6 out of 7 in another). For those FGD participants that did highlight challenges (for themselves or for others), and through CFFs, the most common problems were transport-related (lack of transport or cost of transport), and lack of childcare.

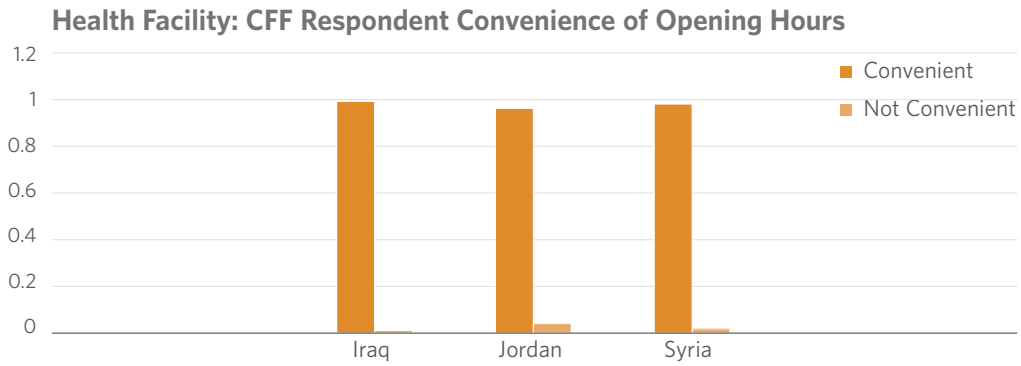
In terms of awareness of services, beneficiaries cited similar modalities of learning about services as WGSS beneficiaries – family, friends, neighbours, and 'word of mouth'. In **Iraq**, camp-based respondents highlighted camp structures as a source of information.

56 UNFPA key informants.

For **cross-border Turkey** operations, TPM reports reference mainly the above sources, with an additional: 1% hearing of facilities through referrals; 2% through outreach; 5% through IEC; and 3% through social media.

Almost all health beneficiaries across all countries think opening hours of centres is convenient.

Figure 11. Convenience of opening hours



Youth centres

For youth centres, there is more of a range across countries vis à vis what other services are available.

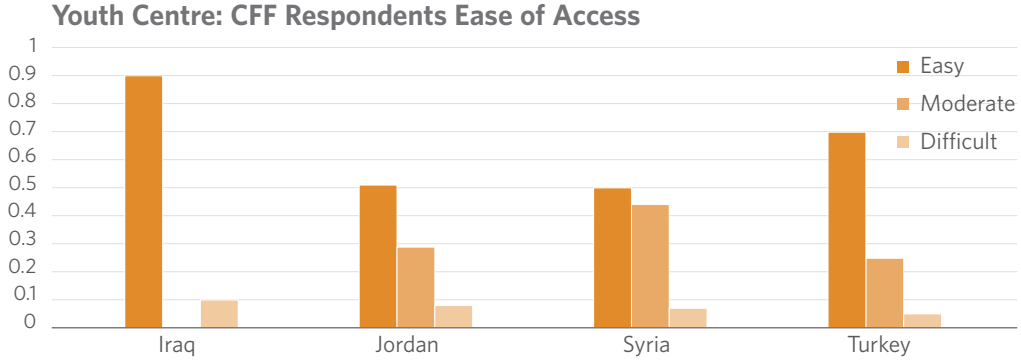
Iraq youth centre staff reported that there are some similar services but that they don't cover all the same activities as UNFPA-supported centres. In certain camps there are also either government youth centres or Student Union youth centres, but they have limited funding to provide activities and services. More than half youth CFF respondents reported that UNFPA youth services were the only services available.

In **Jordan**, the UNFPA Questscope youth centre in Za'atari camp is unique: there are no other spaces in Za'atari which provide such a range of services to the specific youth demographic or that is run by Syrian refugees themselves.

In **Syria**, UNICEF has strong adolescent development and participation (ADAP) programmes operating across the country but their interventions focus more on life skills and general development, while UNFPA-supported centres focus on SRHR and GBV.

In **Turkey**, youth centre staff reported that there aren't so many other services available that target the youth population, either for Turkish youth or refugee youth.[57]

Figure 12. Ease of access to youth centres



57 Youth centre FGD participant.

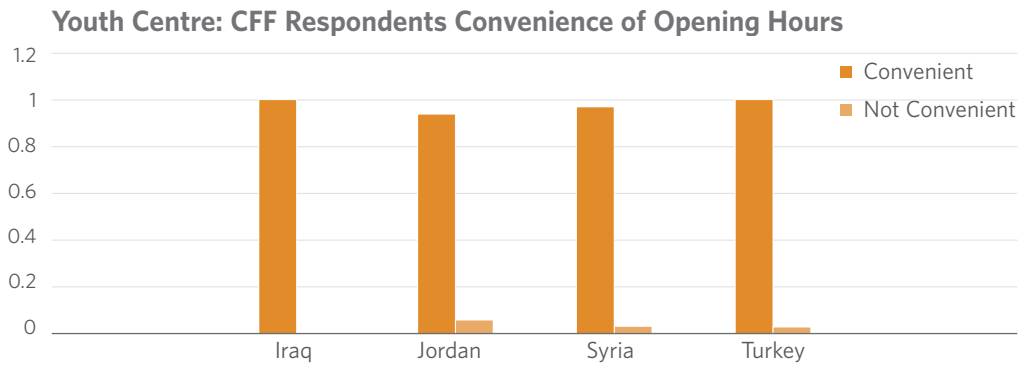
For **Turkey cross-border** operations, the challenges reported vis à vis access are the same as with WGSS, i.e. transport (either lack of or cost of transport). This was the same for Syria. **Iraq** youth centre CFF respondents all referenced distance only. Almost all Turkey youth FGD participants confirmed easy access and no specific challenges were raised by anyone. For youth centre CFFs, one response **referenced sexual harassment**, and some referenced security, transport (cost or and lack of), family restrictions, and distance to location.

Jordan Youth centre FGD participants almost all reported ease of access to the facility, although some referenced COVID-19 as a challenge and some referenced school or work making it hard to find the time to come to the centre. For others, the heat in the summer and the mud in the winter prove problematic. One referenced sexual harassment on the way: *"The guys harass us verbally if we walk through the market"*[58] and this form of GBV was also supported by some CFF respondents.

Almost all **Syria** youth FGD participants agreed that access was easy although some reported it took up to an hour on micro buses, particularly because the centre opens at 3pm which is peak traffic time. Youth with disabilities particularly highlighted transportation difficulties. Girls in some WGSS FGDs and some youth highlighted a lack of free time as a barrier to access.

In terms of awareness of services, beneficiaries cited similar modalities of learning about services as WGSS beneficiaries – family, friends, neighbours, and 'word of mouth'. In Iraq, many youth did cite outreach sessions as a source of information, and also for those that are camp-based structures.

Figure 13. Convenience of opening hours



For Iraq youth, although 100% of CFF respondents reported that opening hours are convenient, some partner staff reported that many young people have asked for services to continue in the evenings. Jordan youth FGD participants in Za'atari confirmed the CFFs which reported that 94% of beneficiaries found the times convenient: many highlighted the fact that it can be difficult to run activities in the evenings anyway (opening times are 8-4, extended to 6pm in the summer) due to camp policies.

Syria youth FGD participants all reflected the CFF responses (which demonstrated 97% of youth find the hours convenient) although some highlighted that in winter it becomes more difficult because it gets dark earlier.

58 Jordan youth centre FGD participant.

Reaching the most vulnerable

In general, UNFPA and partners have made significant efforts to ensure vulnerability is defined, identified, and addressed. However, there are still significant challenges in getting this right. For Iraq WGSS services, staff report that services are offered without discrimination but also recognise that *"people with special needs may find it difficult to reach centres."*[59] Others report simultaneously that programmes are targeted to the most vulnerable but that some particularly vulnerable groups – such as older people – are not targeted. **Iraq** Health facility staff respondents highlight that services are provided to the most affected and marginalised and that, in general, by virtue of the fact that the target areas are among the most vulnerable groups.

Turkey cross-border UNFPA GBV staff and WGSS staff confirm that services are directed at the vulnerable, and there has been significant investment in identifying particularly vulnerable groups in cross-border operations, including adolescent girls, widows and divorced women, older people, and women and girls with disabilities. There is a focus on the category of widows, particularly within the context of NW Syria. Many widows reside in a camp specifically for widows, with restrictions on their movement, and often with sons over the age of 14 who cannot stay in the camp, thus making widows a particularly vulnerable group.

Jordan WGSS staff concede there may be certain groups for whom there are no targeted activities.

For example, they report that many older women (those over 60) complain that there are no specific activities for them, nor can they participate in the activities on offer because of their age. Jordan does have specific programming for adolescent girls and people with disabilities (see next section for more details). Jordan includes refugees of other nationalities in programming in urban areas.

In **Syria,** UNFPA has clear classifications of vulnerability, which include adolescent girls, women in female-headed households, rural women, and those with disabilities. Geographically, the UN system in Syria has annual severity rankings for each governorate to help guide focus.[60] For Syria WGSS, UNFPA report a strategy of integrating all services for vulnerable women and girls (such as those with disabilities, and those who are heads of household) into regular services to avoid stigma. All women and girls are encouraged to participate in group activities and case workers have individual sessions to identify special needs. UNFPA Syria report trying as much as possible to ensure WGSS spaces are disability friendly. Many WGSS FGD participants highlighted their own vulnerable status and how welcome they have felt – particularly those that are widowed or divorced.

> **"People with special needs may find it difficult to reach centres.**

59 Iraq WGSS staff.
60 This also applies to Turkey cross-border operation.

In general, the WGSS and youth centres in **Turkey** do not just provide services to Syrian refugees, but also to refugees of other nationalities who are often considered to be more vulnerable. Furthermore, UNFPA Turkey manage the KRG project which provides services to refugee LGBTI individuals, sex workers, and people living with HIV (PLHIV). This project is specifically and successfully reaching extremely vulnerable refugee populations in a way that other UNFPA COs in the Syria response and more globally struggle to do. In addition, UNFPA Turkey has developed a rural refugee project, in the five provinces with the largest agricultural land and the longest agricultural season, which host significant numbers of refugee migrant seasonal workers. UNFPA has established 12 mobile teams in these five provinces and they work in coordination with provincial health teams with the intention of transferring the project to the Ministry of Health in the same manner that WGSS have been transferred into MHCs.

Adolescent Girls

Specific to adolescent girls, UNFPA across all countries has made continuous improvements to ensure this particular category is well-catered for.

In **Syria**, overall, while adolescent girls in WGSS FGDs highly appreciated the services they receive, it was difficult to establish how many activities were specific for adolescent girls. Adolescent girls did specifically highlight an increase in self-confidence that came from accessing activities within WGSS.

UNFPA **Turkey** has had a youth centre model to try and reach both male and female adolescents and youth since 2015 and in addition, has strengthened adolescent girls services in WGSS by providing youth-friendly service training to service providers.

UNFPA cross-border into Syria operations have strengthened the "Young Mother Club" initiative that targets adolescent girls who are pregnant or have had their first child, and the "My Safety, My Wellbeing" programme that empowers adolescent girls to prevent child marriage. In addition, UNFPA provides training to a variety of partners on adolescent girl friendly initiatives, including training health care providers on how to work with and engage adolescent girls and trainings on adolescent friendly WGSS.

However, responses to a 2019 survey of NGOs operating in north-west Syria show the ongoing need for continued investment and advocacy:

18.75%

of organisations have specific and **pre-designed adolescent girl programmes;**

31.25%

of organisations specifically **track adolescent girls' access to RH services;**

25%

of organisations have provided **training to staff on working with adolescent girls.**

Jordan WGSS participants all highlighted the continuing need for additional activities specific to adolescent girls, including economic empowerment courses for girls, and educational and psychological services for girls.

In **Iraq,** implementing partners do have adolescent girls focal points (hired by the implementing partner and funded by UNFPA) and UNFPA has an adolescent girls technical manager position.

"It helped us a lot. My sister is deaf and mute, and she benefitted a lot in the courses with the help of the facilitators. She became much better.

People with Disabilities

In 2017, there was limited mention of people with disabilities from FGD participants: when asked about marginalisation or exclusion, women referenced IDPs, older women, unemployed women and women with emotional issues, including GBV victims, widows, women that lost a family member, adolescent girls, divorcees and unmarried single women. Most participants reported that the WGSS is open to everyone and did not seem to consider the accessibility issues for those with disabilities.

By 2019, key informants across the majority of health facilities reported that beneficiaries with both physical and mental disabilities had recently accessed services. The key finding emerging from the 2018/2019 assessment on this thematic area is that women and girls living with disabilities are accessing UNFPA supported services – however their participation remains limited and they do not benefit from the services to the same degree as many of their peers. Several FGD participants pointed out that they know of people with disabilities that would like to come to the centre but do not come. The assessment also found out that infrastructure is often not designed in a way that is disability-friendly. Small spaces, lack of stairs, lack of air conditioning, etc. are important matters that affect PWD and other groups, for instance older women.

The 2020 assessment highlights clear progress, although there is still work to be done to have a consistent and high quality approach to disability inclusion across the Syria regional response. This year, many women and girls with disabilities spoke for themselves within FGDs.

> *"I used to go to the Hearing and Speech Impaired Children Association, before coming to Nour Association, but Nour Association has many services that other centres do not have."*[61]

61 Syria youth centre FGD participant.

> *"I also benefitted a lot from coming here. For instance, as a woman, I wasn't able to go outside before. I was like a child. But now I can go out on my own. I live my own life not anyone else's. For example, I have a disease but here everyone accepts you as you are. So they don't say, you have a disease, we can't work with you. They accept people here as they are."*[62]

As with adolescent girls, UNFPA **Iraq** has a specific output in the Country Programme Document (CPD) for people with disabilities: however, the 2020 Annual Report acknowledges that this is not systematically reported by implementing partners.[63] Youth centre staff in Iraq acknowledge that the centres and activities are not prepared for people with special needs, particularly where activities are carried out in "caravans" which are not accessible for youth with physical disabilities. In addition, there is recognition that *"the societal view affects them greatly":* [64] staff report that it is not just physical barriers to access for youth with disabilities, but also stigmatisation and cultural barriers.

WGSS staff report that some people with special needs access services at WGSS and that *"we try to provide assistance to them as much as possible"*[65] but as with the youth centre staff responses, they confirm that a major obstacle is cultural / societal. Another major obstacle is roads and paths leading to service units are inaccessible for those with physical disabilities, even if the centre itself is accessible. One of the obstacles that people face is the lack of societal acceptance of them, and the lack of suitable streets and transportation to transport them.

In **Jordan,** a global evaluation[66] reported that implementing partners have all received disability training and that for Za'atari camp youth centre, UNFPA and Questscope had ensured the physical space was disability-friendly. Indeed, youth centre staff confirm that youth with disabilities are meaningfully included within the programmes and that the youth volunteers within the centre are very proactive in reaching out to youth with disabilities. This was supported by one FGD participant: *"It helped us a lot. My sister is deaf and mute, and she benefitted a lot in the courses with the help of the facilitators. She became much better."*[67] However, it is also acknowledged that a big challenge is getting to the centre, with the need for wheelchairs (and the unsuitability of terrain for wheelchair or an escort for those that are blind) and these challenges persist.

UNFPA and IP GBV staff report that there are some WGSS that are well sensitised to working with particularly vulnerable individuals, such as older people or those with disabilities, but there are still access difficulties for people with physical disabilities. WGSS FGD participants highlighted that there should be more services for people with disabilities and that both physical accessibility and societal norms prove to be barriers for access.

Syria CO report that the list of criteria for assessing WGSS or clinics includes disability aspects, confirming that during 2020, all activities were moved to the ground floor, and facilities have started to include ramps and toilets for people with disabilities, where possible, in some centres.

WGSS FGD participants confirm that centres are welcoming to women and girls with disabilities but many participants emphasised that it would depend on what type of disability. Others strongly confirmed the *lack* of services for people with disabilities and this was a clear differentiation between different FGDs in different WGSS.

Staff across both types of service units in **Turkey** confirm that centres are disability and child friendly, but WGSS staff admit to struggling with accessibility issues and again highlight the cultural 'sensitivities' for those with disabilities to leave home. UNFPA WGSS staff admit that these are issues that have been discussed for years and they are still keen to achieve better services for those with disabilities. Where WGSS centres are not disability-friendly, there is still an attempt to reach those with disabilities through health mediators or through their families who come to the centre. UNFPA Turkey has the added complication of language, with a lot of work being conducted through translators, so training on disability inclusion is not just training for service providers, but training for all translation staff as well.

62 Turkey WGSS people with disabilities female FGD participant.
63 UNFPA. 2019 Annual Report – Iraq. 2020.
64 Iraq youth centre staff.
65 Iraq WGSS staff.
66 UNFPA. Evaluation of UNFPA support to gender equality and the women's empowerment across development and humanitarian settings 2012-2020. Jordan case study: country evidence table. 2020.
67 Jordan youth FGD participant.

UNFPA **Turkey cross-border** operations are still working on accessibility and inclusion of vulnerable persons with disabilities to the services provided in **all** its supported delivery points. Partner staff report that not all facilities are completely disability-friendly yet. Health facility staff highlight the measures put in place for both older people and those with disabilities, including having transportation available for those with limited mobility (confirmed by WGSS FGD participants). Partners highlight that UNFPA require tracking against a PWD indicator for services. One TPM report confirms that: *"Most facilities have some sort of equipment or adapted infrastructure to ease access for beneficiaries with limited mobility."*[68]

But the report also suggests that: *"Despite these measures being implemented differently across facilities, it would be important to harmonise the approach to better cater to the needs and priorities of PWD and other vulnerable patients by adding railings and ramps, seated toilets, wheelchairs, crutches, and other support. When these adaptations are not possible, facilities should consider conducting more outreach and home visits to bring services to those who cannot easily move to the facility itself for reasons other than transport."*[69]

However, some challenges still remain, both in terms of ensuring accessibility (physical and otherwise, and recognising accessibility of the centre itself and accessibility of getting to the centre – i.e. inappropriate roads, and not being able to use public transport as two distinct challenges), and also addressing the strong societal and cultural barriers that prevent people with disabilities, particularly women and girls, from taking their place in society and living their lives to the fullest.

The challenges therefore fall into different categories:

- Staff not being trained on disability inclusion (and note in the next section, on efficiency, that a number of staff across all three service unit types are requesting more disability inclusion training);
  - this includes knowledge, attitude, and practice; recognition of what disability is; understanding the importance of including those with disabilities in all services and activities; and implementing the practical and pragmatic solutions to achieve this.
- Access to the front-door of the centre (i.e. external challenges with roads and transport);
- Accessibility into and within the centre (ground floor only, accessible toilets, ramps etc);
- Societal and cultural barriers and stigma.

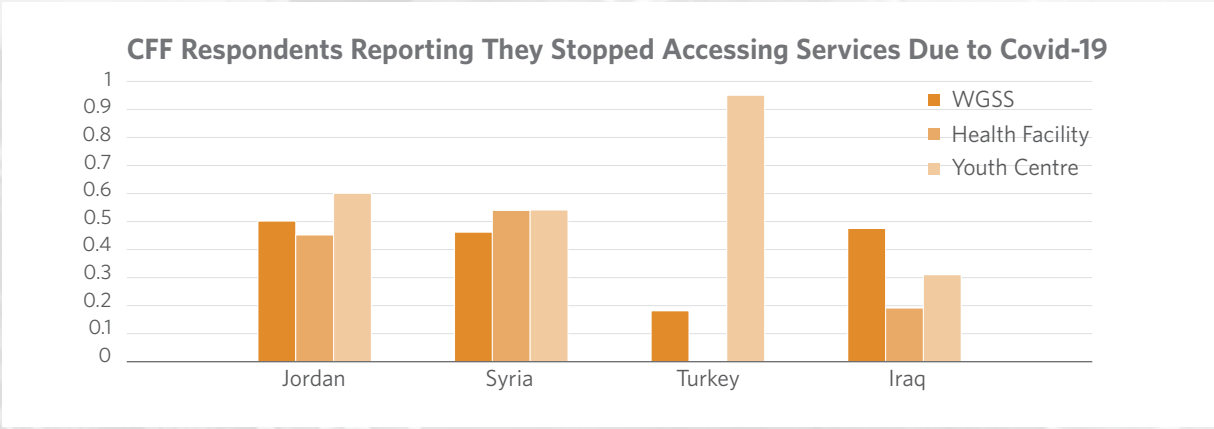
> **"Most facilities have some sort of equipment or adapted infrastructure to ease access for beneficiaries with limited mobility.**

68 SREO TPM Report.
69 Ibid.

"The key finding emerging from the 2018/2019 assessment on this thematic area is that women and girls living with disabilities are accessing UNFPA supported services – however their participation remains limited and they do not benefit from the services to the same degree as many of their peers.

COVID-19 – effects on accessibility, and UNFPA mitigation measures

Figure 14. CFF respondents who reported they had stopped accessing services (for an undefined amount of time) due to COVID-19



The reasons for stopping access to services varied by country and service unit.

Figure 15. Reasons provided by FGD participants / CFF respondents for stopping access to services, by country and service unit.

	WGSS	Health Facility	Youth Centre
IRAQ	curfew in place; fear of infection; economic situation; protection in camp was suspended during curfew; increased difficulties in obtaining permits for movement in camps.	No reasons provided.	fear of infection; requirement to enter labour market / find employment; trauma on losing family members to COVID-19
JORDAN	fear of infection; closure of other government services;		No reasons provided
SYRIA	fear of infection; lack of transportation during the peak of the pandemic; fear of passing the virus to family members; forbidden by parents (girls).	No reasons given	fear of infection; some people returning to villages; group activities were forbidden; concerns about effectiveness of mitigation measures put in place; forbidden by parents.
TURKEY	fear of infection; fear of using public transport to reach facilities; sickness within families so individuals are isolating.		Turkey youth reported that they stopped accessing centres because accessing activities and services online was so easy.
TURKEY CROSS-BORDER	forbidden by parents; fear of infection (particularly people with disabilities).	Access continued	

All UNFPA countries have put in place a number of specific mitigation measures for COVID-19 adaptation.

These include, across all service units:

1. Physical adaptation of face-to-face services:
   - reduction of number of participants for any activity;
   - commitment to social distancing and use of masks and gloves;
   - Allocation of specific tools and equipment for each participation during activities, and sterilisation between uses;

- putting outdoor waiting chairs with consideration for spacing;
- reduction of the use of forms that were previously used by women.[70]

2. Provision of online services:
   - providing awareness activities through social media applications;
   - provision of online / telephone services;
   - training of service providers for remote service provision.
3. Raising awareness of COVID-19:
   - providing awareness sessions about Coronavirus and how to prevent it.
4. Duty of care to staff and volunteers:
   - reducing the number of mobile teams.;
   - provision of PPE;
   - reduction of working hours;
   - ensuring all employees had computers, mobile phones, internet, and could work from home;
   - rotating staff who were providing face-to-face services.

2.3 Efficiency

This dimension included the following questions which were asked as applicable through KIIs, FGDs and / or CFF.

1. Are there enough staff in this centre? 2. Have staffing needs changed / become more or less problematic during covid-19? Why? 3. Have you recently received any training? 4. What type of training is needed for staff members of this centre? 5. Is there any specific training that is needed for delivering services during COVID-19? 6. Do you feel that you have the necessary equipment and supplies to provide services and activities effectively? – If not, what is missing / in short supply? 7. How have things changed with regard to supplies and equipment during COVID-19? 8. Are you using UNFPA RH kits? If so, what kits are most useful and why? 9. Do you have post-rape treatment kits? If yes, have you ever used it? – For GBV survivors? – For other purposes? 10. What are the biggest challenges you are facing in this centre?

This information below is collated across all countries to summarise the **efficiency** of UNFPA services within the Syria regional response programme. This section of the report is divided into three components:

Efficiency of WGSS;

Efficiency of health facilities;

Efficiency of youth centres;

70 No further information was provided on this.

Women and Girl Safe Spaces

Staffing: There was a range of responses with regard to sufficiency of staffing pre-COVID-19, with generally no gaps in WGSS staffing reported in Syria but across Iraq, Jordan, Turkey, and Turkey cross-border, respondents reported an inadequate level of staffing. Turkey in particular struggles with enough translators, a challenge not faced by other countries.

In relation to COVID-19 specific requirements, Iraq and Turkey cross-border reported an increased need for outreach workers and mobilisers, but Jordan, Syria and Turkey all generally reported no additional staffing needs for the pandemic.

Training: WGSS staff across all Syria regional response countries have received significant training, with most common topics being:

- GBV, general;
- GBV case management;
- PSS counselling and support;
- Management of referral pathways;
- Confidentiality protocols;
- Project management (Jordan only);
- Working with people with disabilities;
- SRHR.

Note that only respondents from cross-border Turkey specifically reported having received training on protection from sexual exploitation and abuse (PSEA).[71]

Topics of training requested for the future (some of which are repetitive of those trainings already received, and requested as ongoing requirements both to upskill and learn more, and due to turnover of staff) include:

- GBV IMS (Iraq only);
- MHPSS counselling and protocols;
- More training for working with people with disabilities (across all countries);
- CMR (only requested from cross-border Turkey partner staff);
- Resource mobilisation and grant management activities – proposal writing and report writing.

Specifically for the COVID-19 pandemic, topics for training both received and requested can be categorised into service provision topics and ancillary topics (computer training etc) which became clearly critical for all remote and virtual services and activities. Again, training requests were often duplications of training received, where staff desired ongoing support and training, and shared their concerns that new staff received training.

- Remote case management / remote PSS counselling;
- Delivering services in different ways due to the pandemic;
- COVID-19 prevention, protection, and mitigation measures;
- Training on addressing the effects of the pandemic including increased domestic violence, and how to measure, prevent, and respond;
- COVID-19 and pregnancy;
- Computer, internet, and social media for services and specific virtual platforms (i.e. Zoom) training.

71 The 2019 global UNFPA humanitarian capacity evaluation noted that "UNFPA has significantly increased the level of guidance on UNFPA responsibilities in PSEA for UNFPA staff, programmes and partners but this has yet to manifest in a tangible manner across country-level implementation, where expertise within UNFPA remains basic." (https://www.unfpa.org/sites/default/files/admin-resource/Final_Humanitarian_Evaluation_Report_pages.pdf). However, PSEA is a critical issue for all humanitarian actors, and for UNFPA even more so from 2021 when the Executive Director of UNFPA becomes global champion for PSEA so it is important that investment is provided in this area, not just for training for UNFPA staff but for training for all front-line IP staff and service providers in service units (this being more critical as these are the staff who have direct contact with beneficiaries) and across all aspects of prevention and response.

Supplies: Overall there was a wide range of responses with regards to supplies. Iraq, Turkey and Syria reported some shortage of supplies at different times and Turkey cross-border partners reported delays in receiving some supplies that were procured from outside Syria. Generally, however, the supplies issue was not reported as being dire anywhere. Jordan reported no supplies issues but did refer to infrastructure, with some partners highlighting the need to improve physical space, for example for fire safety, and to have dry (covered) outdoor space – specific to COVID-19 considerations – so they could conduct activities more safely.

In respect of COVID-19, some countries reported some lack of quality masks, or lack of masks for beneficiaries, but this was less important than the reported shortage of computers, phones (with camera) and internet access, which was overwhelmingly highlighted by all countries.

Challenges: For all countries, partner staff highlighted COVID-19 as the biggest challenge overall. Subsequent to this were issues such as:

- Lack of income-generating activities (IGA) and / or cash assistance (Iraq, Syria, and cross-border Turkey);
- Lack of transportation / expensive transportation for beneficiaries to reach WGSS (Iraq and Syria);
- Government approvals (Jordan, Syria and Turkey).

Health Facilities[72]

Staffing: Syria and Jordan health centres reported no gaps in staffing and no additional staff required for the COVID-19 pandemic. However, Iraq and Turkey cross-border operations reported both a general shortage of health facility staff and a clear need for additional staff during the pandemic. Iraq highlighted that during the peak of the pandemic, many staff were transferred from the clinics to larger hospitals as part of the COVID-19 response and other staff were absent through being sick or isolating due to high risk (such as pregnancy). Turkey cross-border reported additional staff were required to help raise awareness of COVID-19 and the measures put in place, and access to online support, ensure all infection prevention modalities are in place and being monitored, and regulating entry to hospitals and clinics.

Training: Health facility staff across all Syria regional response countries have received significant training, with most common topics being:

- SRH and SRHR;
- GBV, general;
- GBV case management;
- PSS support;
- Children and malnutrition;
- CMR (Turkey cross-border only);

Note that only partner staff from Turkey cross-border operations specifically highlighted CMR training.

Topics of training requested for the future (some of which are repetitive of those trainings already received, and requested as ongoing requirements both to upskill and learn more, and due to turnover of staff) include:

- working with young adolescents (under the age of 15);
- working with people with disabilities (Iraq and Syria);

72 Note that UNFPA Turkey do not manage any health facilities within their programme.

Respondents from all countries reported having COVID-19 adaptation, protection and prevention training and also requested continuing training on this subject matter.

- updated family planning options and protocols;
- project management and grant management;
- social norm and behaviour change;
- PSS support, basic principles;
- Management of childhood diseases.

Respondents from all countries reported having COVID-19 adaptation, protection and prevention training and also requested continuing training on this subject matter.

Supplies: Both **Iraq** and **Syria** reported a general shortage of certain items before the pandemic started, with respondents from Syria linking this specifically to current exchange rate issues in Syria. Iraq and Syria also both highlighted issues with RH kits vis à vis certain contents being inappropriate for the context, while Iraq also reported an issue with short expiration dates of some items.

Jordan and **Turkey cross-border** operations reported no shortage of supplies before the COVID-19 pandemic started and Jordan confirmed this has not changed since COVID-19. However, Turkey cross-border operations and Syria both highlighted issues with quality masks and hand sanitiser since the pandemic began (there is an inter-agency response to this for Turkey cross-border operations, with OCHA allocating funds from the Humanitarian Fund for PPE) and Turkey cross-border highlighted that shortages of other medical supplies are increasing since the pandemic began.

Challenges: Unlike WGSS respondents, no health facility respondents actually reported COVID-19 as being the biggest challenge. Instead there was a wide variety of challenges highlighted across Iraq, Syria, Jordan and cross-border Turkey, being

- low awareness of services (Iraq and Jordan);
- the need to work more with men on family planning (Syria and Jordan);
- government approvals / local authority control (Syria);
- limitations of the referral system (Syria);
- concerns on sustainability of services (Jordan);
- government measures during COVID-19 (Jordan).

Youth centres[73]

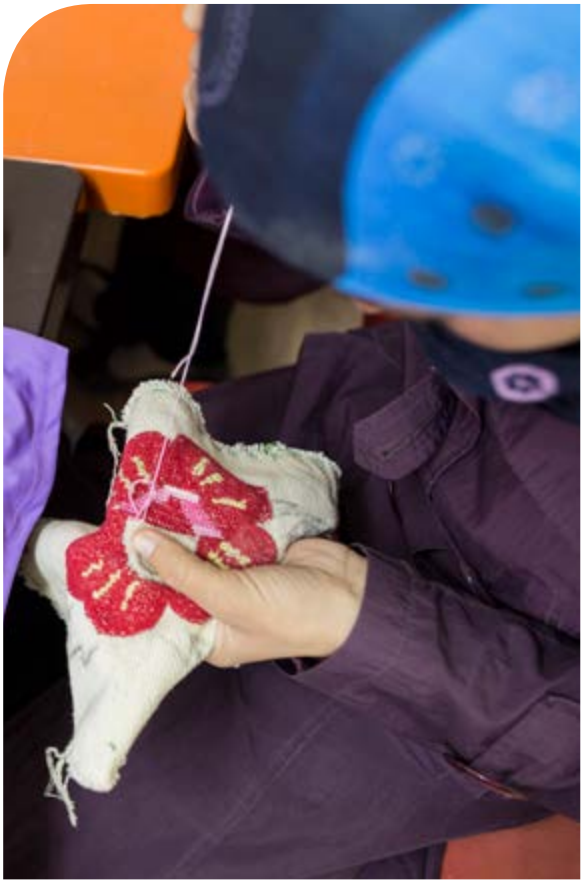
Staffing: Youth centre respondents from Iraq, Jordan, and Syria all referenced adequate staffing pre-COVID-19 times, and Syria reported this not changing: Jordan however reported already recruiting more outreach volunteers in the youth centre in Za'atari in response to COVID-19. Turkey highlighted inadequate staffing in youth centres even before the pandemic, specifically based around the fact that health service providers for the Turkey youth centre model represent a very specific job profile: a role which requires being a qualified medical service provider but also experience working with youth, experience working with vulnerable refugee populations, and Arabic / Kurdish speaking. Both Turkey and Iraq report requiring more youth centre staff since COVID-19 started. Syria youth centres report managing adequately with current staffing levels.

Training: Across all countries youth centre staff have received various trainings from UNFPA:

- Life-skills;
- Providing educational and vocational training to young people;
- Non-violent communication;
- Gender;
- GBV;
- PSS counselling;
- Referral pathways;
- Media and communication;
- Self-care;
- Peace-building (Iraq only).

Requests for more training revolved around topics such as:

- SRHR;
- Working with youth in creative ways;
- Communication skills;
- Working with people with disabilities;
- Referral pathways;
- Grant management and resource mobilisation – proposal writing, report writing;
- Computer skills (Turkey only).



Specific COVID-19-related training provided include general COVID-19 adaptation, protection, and prevention and also, specifically in the case of Jordan, WhatsApp case management training.

Supplies: Iraq, Jordan and Turkey youth centre respondents all reported no gaps in supplies, although Turkey highlighted that with increased violence and stress in the community, coupled with increased youth unemployment all due to COVID-19, they foresee the need in the future to increase activities and services to youth and therefore shortages of funding and supplies were predicted. Syria highlighted a gap of computers for youth centres.

Both Iraq and Turkey highlighted the clear demand for dignity / hygiene kits for youth during this year.

Challenges: Only respondents from youth centres in Turkey highlighted COVID-19 as a challenge. In Iraq, Jordan and Syria, the biggest challenge was reported as lack of funding, with Jordan also reporting restricted movement into and out of camps as a challenge and Syria referencing disrupted electricity and unreliable internet as a significant challenge.

73 There are no youth centres supported through the Turkey cross-border operations.

2.4 Recommendations

Many of these recommendations will require additional financial investment from UNFPA, therefore these should be included in upcoming proposals and funding opportunities.

1. **Plan for expansion of gender-transformative interventions including income-generating activities in WGSS.** Income-generating activities – IGA and vocational skills linked to employment and earning potential are the most requested activities in WGSS across all countries. While all countries currently offer differing levels of services, it might be worthwhile to consider a regional strategy for IGA within WGSS which might involve: (a) partnerships with other agencies (i.e. UN Women or UNDP) or regional or national NGOs, technical institutions, or other organisations or private sector; (b) a review of the types of IGA being offered, noted that women and girls are not requesting any non-traditional skills (activities such as hairdressing and sewing are the most requested) but this presents an opportunity for UNFPA to infuse a more gender-transformative approach within the WGSS model; and (c) recognising that UNFPA is not and should not be advocating for adolescent girls to work, but that that they can learn new skills that are gender-transformative, which will later have a positive economic outcome.
2. **Develop interim guidance on addressing male survivors of sexual violence.** While it is clear that that UNFPA ensures the provision of health services for any survivor of sexual violence (women, men, girls and boys), it might be useful for the Syria regional response, under the auspices of the Hub which itself sits under ASRO,[74] to develop some interim guidance on addressing male survivors of sexual violence until global-level guidance is available to assist COs in navigating how to best respond.
3. **Rationalise male engagement and activities through GBV programming with a clear statement that WGSS are for women and girls only.** The regional Syria regional response, under the auspices of the Hub which itself sits under ASRO,[75] should re-issue guidance to assist COs in navigating the requests from women and girls themselves for activities for their male relatives at the WGSS; with clear examples of how UNFPA should engage men in prevention through accountable practices and how that can work outside of WGSS space; and the clear global guidance to ensure WGSS is critically protected as a women and girls only space.
4. **For youth centres, a rationalisation of the target audience would be useful.** As different COs are aware, there is a range of different definitions of 'youth' and national guidelines are often different from the global definition of youth (being 15-24). With the new IASC guidelines on young people coming out in 2021, UNFPA should ensure that they are rolled out in all its responses. In the short-term, UNFPA should ensure that its youth centres are structured to ensure that the provision of services to older men and women does not inhibit the provision of services to the adolescent and early twenties demographic which is the core target audience of UNFPA youth focus.
5. **Adolescent girls: enhance the Hub's ongoing initiatives of sharing good practices, and support the testing and replication of successful interventions in different settings.** The Hub should build on its programme of webinars and briefs webinars and briefs for UNFPA CO staff and implementing partner staff to embed continuous learning and sharing on working for and with adolescent girls.
6. **People with disabilities: categorise the specific factors of disability exclusion and map specific actions for each.** While progress has been made in addressing the needs of PWD, UNFPA should go further to ensure they are truly reaching the most vulnerable PWD, by analysing the factors of exclusion. This categorisation should use, as a basis, the four highlighted in this report: (1) societal; (2) the physical environment outside of UNFPA-supported centres – roads etc; (3) the physical environment inside of UNFPA-supported centres); and (4) knowledge, attitude and practice of service providers.

Mapping of specific actions will take into account different dimensions of action including:

a. how much is under UNFPA control – i.e. factors number 3 and 4 are much more within control of UNFPA than factors 1 and 2, which does not mean that UNFPA should not consider how to address factors 1 and 2 but that influence is more limited;

b. time frames for how to address different factors – i.e. factor 1 will take many years to address as

74 Noting that there is a complication with Turkey CO and the Gaziantep office for cross-border operations which are under the EECARO region rather than the ASRO region: this would be something internally for UNFPA to manage.

75 Noting that there is a complication with Turkey CO and the Gaziantep office for cross-border operations which are under the EECARO region rather than the ASRO region: this would be something internally for UNFPA to manage.

social norms related to people with disabilities change slowly over time, but perhaps there is a way to contribute to that change through engagement of youth in community communications or other ways, and factor 2 is something UNFPA can perhaps only mitigate – for example, with provision of transportation – rather than actively address;

c. cost involved in change – i.e. factor 3 is under UNFPA control but might be a high-cost investment to change or alter locations to ensure physical access is disability-friendly – including toilets etc; and

d. complexity – i.e. addressing knowledge, attitude and practice of service-providers in UNFPA-supported is more than the provision of a one-off training: it requires an ongoing plan for training, monitoring, mentoring, and follow-up to ensure not just knowledge but attitudes and practice are disability-inclusive for both physical and mental disabilities.

UNFPA might consider stronger regional partnerships with Humanity and Inclusion (HI) or, if they have limited capacity, any other organisations and institutions.

7. **Create a regional plan for mapping and monitoring the return on investment of IEC and outreach for raising awareness of WGSS.** Most beneficiaries across all service points – WGSS, health facilities, and youth centres – cite 'word of mouth', friends and family (noting that 'word of mouth' is really synonymous with friends and family) as how they heard of services. This is expected and does not pose a problem at all, but to ensure that UNFPA has exhausted all avenues to reach the most vulnerable women and girls (and youth) with information about services UNFPA could consider investing in pilots to use a more marketing approach to awareness about the WGSS. *This could support an analysis of* the cost-efficiency of traditional awareness v 'marketing' methods to inform about services.

   a. If one or more operations has the resources for a pilot project to cost-assess different marketing strategies (traditional modalities of advertising such as radio and flyers, compared to digital media advertising) this could be used to inform the regional response more broadly. UNFPA should use this data to re-assess IEC and outreach for raising awareness of services accordingly.

   b. Additionally, as 'word of mouth' is the most common way of women and girls finding out about WGSS (this is both normal human behaviour – most individuals are more likely to attend a service when it has been recommended by someone they know and trust, and this is also a sign of quality of services) it might be useful to consider how UNFPA can be more proactive in ensuring this happens, in terms of incentivising women and girls to spread the word and to consider the most vulnerable in their communities who may benefit from services.

7. **COVID-19: Institute an ongoing practice of collating and sharing COVID-19 solutions and unexpected positive outcomes.** The UNFPA Syria Regional Response Hub has already produced various reports on COVID-19, focusing on the impact of the pandemic on women and girls, and how to report on GBV during the pandemic, as well as best practices in programme implementation during COVID-19. While the best practices publication highlights practical solutions and pragmatic adaptations for the pandemic response, it was produced very early on in the pandemic and therefore was too early to recognise how the adapted ways of working will take shape over the longer term. Many of these adapted ways of working will remain in place only while necessary, but some may become modalities of working and reaching people that remain either as replacements for traditional modalities or to continue as parallel modalities in the future: a better 'new normal'.

   It would be useful for UNFPA Syria Regional Response Hub to capture best practices from COs on a regular basis with a view to publishing or sharing more widely in 2021 or 2022 with clear evidence of what works and how service provision in the post-pandemic 'new normal' can be maximised for effectiveness and efficiency. It is recommended to talk to IP staff and capture the unexpected positive outcomes of programming during the COVID -19 pandemic, with questions that try to capture any unexpected benefits of adaptation, and what should continue during the new normal.

8. **Country Offices should use the raw data collected within this report to analyse more closely specific issues arising from the feedback.** This report collates a significant level of data to present a regional assessment of the UNFPA response. While there are country chapters, these are also bound by the format of this assessment report as agreed within the inception phase of the assessment and presented at country level, not at facility. However, all countries hold the raw CFF and FGD data collected which provides rich data at the facility level that countries can use, with support from the Hub, to address any specific localised issue.

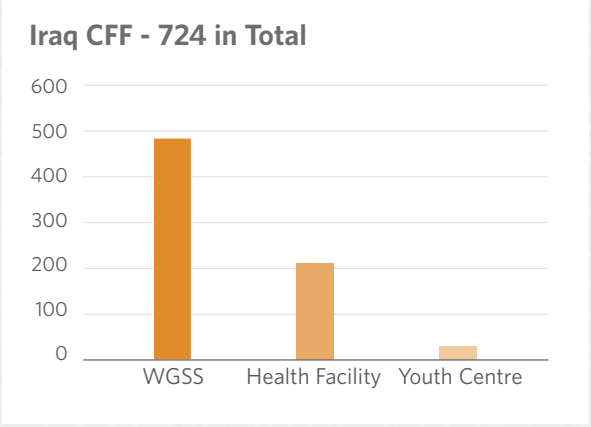
Section 3

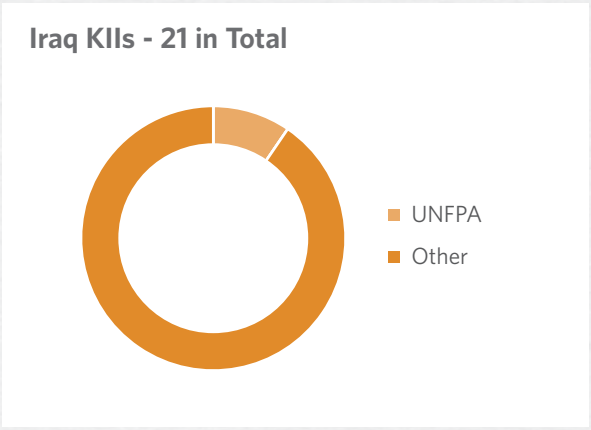
Country Reports

Section 3. Country Reports

IRAQ

Figure 16. Iraq data sources





IMPACT

UNFPA Iraq provides integrated SRH services through support to SRH facilities, WGSS, and also supports Youth services. There are 56 static RH facilities across Iraq, 22 delivery rooms in both camp and non-camp settings, and 4 maternity hospitals. To date, 7 health facilities previously managed by UNFPA have been transferred to the Government of Iraq.

Health facilities provide a number of services across with many of them free of charge.

Safe spaces for women and girls (WGSS) in Iraq provide GBV case management services, referrals, counselling, psychosocial support, awareness sessions, distribution of dignity kits, vocational training, specific adolescent awareness and life skills courses. There are 67 WGSS across 7 governorates.

In terms of youth, 4 UNFPA supported youth centres provide recreational, cultural, sports, and educational courses in addition to life skills and peace building skills. Since the beginning of the youth programme, UNFPA has worked to build the capacity of 268 youth on mediation skills and a total of 7,229 youth participated in prevention of violence and extremism (PVE) activities. As a result of this, there are youth provincial action plans being rolled out across 5 provinces in 2020.[76]

76 No further information about the progress of these plans was provided through this assessment. Provinces are Ninewa, Anbar, Diyala, Baghdad and Najaf.

The impact of all services is high, as reported by beneficiaries themselves. 96% of WGSS beneficiaries, 77% of health facility beneficiaries, and 100% of youth centre beneficiaries all reported their lives being better because of the services received in the UNFPA supported centres.

Figure 17. Ranking of importance of receiving services, from client feedback forms:[77]

	Absolutely essential	Very important	Of average importance	Of little importance	Of no importance
 WGSS	8%	57%	17%	14%	4%
 Health Facility	17%	59%	13%	11%	0%
 Youth Centre	10%	24%	45%	17%	3%

In terms of being safe and respected in the facilities, 2 out of 484 WGSS beneficiaries stated they did not feel safe (no further comments given, response through CFF) and the same two highlighted they did not feel respected.[78] All health facility and youth centre beneficiaries reported feeling safe and respected.

According to UNFPA and service providers, IDPs, refugees, and host communities are primarily in need of psychosocial support, including emotional support and psychosocial counselling, followed by primary health care services, including medical consultations and provision of medications, and thirdly food and livelihood support. Returnees are primarily in need of food and primary health care services, followed by livelihood opportunities and safety and security, and thirdly education services.

Suggestions for improvement for all three service unit types include:[79]

- Content of services [no further information provided];
- Improved (bigger) spaces;
- Improved location of facility, opening times of facility.

COVID-19 IMPACT

UNFPA and service providers report that during the COVID-19 outbreak, the process of referrals for further health and protection services has been challenging. The Ministry of Health (MoH) prioritised the response to COVID-19 which impacted on already stretched SRH services. Added to

77 In Iraq there were no FGDs conducted and an expanded CFF form. This had one question on whether beneficiaries reported their lives being better because of accessing UNFPA services (as highlighted in the above table) and the standard CFF question comparable to all other countries as to the importance of accessing services – absolutely essential, very important, of average importance, of little importance, or of no importance.
78 This may be something UNFPA Iraq should follow up with the specific facility.
79 Suggested changes were provided from a list of choices and respondents choose more than one, so it is difficult to quantify exactly the scope of these suggested changes.

that, social distancing and curfews restricted movements but also a sense of fear reduced people's access to services in general. UNFPA reported it being easier to adapt for GBV where some services and support could be provided virtually, than for RH services where women and girls needed to be physically present. However, there are also reports of intimate partner violence (IPV) increasing significantly because of lockdowns, increased unemployment, and increased household stress – and this means demand for services has increased. Safe spaces for women provided remote services until work resumed in the centres because there was an urgent need for case management services with the increase in violence within families.

For health facilities, some service providers reported that some women have stopped coming but that the majority of women have attended as before. Others reported that in some centres all services were halted, which had a big impact on women and furthermore, the difficulty of moving between governorates resulted in many challenges.

For WGSS, services stopped across most centres but services for case management continued remotely, as referenced above. For camp-based populations, there was increased difficulty in reaching services in camps where curfews were strictly enforced. Service providers report that for non-camp refugees, communication was easier through telephone and social media. In-person WGSS services only stopped for a very short period. When services re-opened, they did so with smaller numbers of women and girls accessing the spaces although there was no specific feedback as to why this is the case.

For youth centres, they stopped on the instructions of the government, and service providers reported that the youth faced many difficulties, particularly in camps. For many youth, these centres are the only recreational place in the camp and while activities and training was offered online, inevitably that did not reach all youth. Further, the increase in family violence (as referenced above) also impacted on youth as did the economic difficulties that many families faced, with youth being required to contribute as much as they could to families.

However, according to beneficiaries themselves, 46% stopped coming to WGSS services – almost half, and 31%, a third, stopped coming to youth centres. But only 4% stopped accessing health facilities.

Figure 18. How badly CFF respondents were affected by COVID-19 – Iraq

	Not affected by COVID-19	Badly Affected by COVID-19	Very badly affected by COVID-19	Stopped access to services due to COVID-19
WGSS	18%	50%	22%	46%
Health Facility	27%	31%	41%	4%
Youth Centre	7%	62%	31%	31%

ACCESS

Figure 19. % of CFF respondents who know of other services[80]

CFF respondents who do not know of other services, or state there are no other services

Approximately a third of WGSS beneficiaries and health facility beneficiaries (36% and 29% respectively) do not know of other services, or state explicitly that there are no other similar services around. For youth centres this is even higher, at 41%.

Youth centre staff reported that there are some similar services but that they are limited to specific activities. In certain camps there are also either government youth centres or Student Union youth centres but they have limited funding to provide activities and services. More than half Youth CFF respondents were clear that UNFPA youth services were the only services available.

Some WGSS staff initially reported that GBV services are not available in the regions except through UNFPA-supported centres but then referenced institutions that provide material support for women with some services related to violence against women, just with a different methodology to UNFPA partners. Other WGSS staff reported that there are many international institutions and civil society organisations that provide similar services. Actually, nearly two-thirds of CFF respondents did report that similar services were available elsewhere.

For health facilities, some interviewed staff reported that there are no services similar to the UNFPA-supported services outside of the private sector, with associated high costs.

Figure 20. % of CFF respondents who report facilities being difficult to access

CFF respondents reporting facilities being difficult to access

Overall, at least 90% of CFF respondents across all service unit types report facilities being easier to access. For challenges to access, various issues have been noted by staff, previous reports, and indicated on CFF forms, including distance to facility, stigma, lack of awareness of services, and lack of awareness of facilities.[81] In Iraq, mobile teams have been put in place to try to reach geographically dispersed and displaced women and girls.[82]

80 It might be useful for UNFPA Iraq to review the CFF and extract localised data on this point to assist with future geographical planning.
81 From both CFF responses and UNFPA. 2019 Annual Report – Iraq. 2020
82 UNFPA. 2019 Annual Report – Iraq. 2020

WGSS CFF respondents referenced distance, stigma, and parents not allowing access as challenges to accessibility. Both health facility and youth centre CFF respondents all referenced distance only.

In terms of awareness of services, beneficiaries of different service units receive information about the services in different ways. For WGSS beneficiaries, it is friends and family, and then camp structures (for the camp-based WGSS) and then brochures. For health facility beneficiaries, it is camp structures first, and then neighbours / friends and family. For youth centre beneficiaries, it is outreach sessions first, and then friends, and then camp structures.

Figure 21. Convenience of opening hours

CFF respondents reporting opening hours are not convenient

WGSS

7%

Health Facility

1%

Youth Centre

0%

A vast majority of all respondents felt that the opening hours of clinics / facilities / centres were appropriate and suitable. For WGSS, this was 93% of the respondents completing CFFs. This was supported by WGSS staff interviews who highlighted that the morning opening times were very convenient for beneficiaries but also that many women and girls were requesting Saturday services as well.

For youth, although 100% of CFF respondents reported that opening hours are convenient, some partner staff reported that many young people have asked for services to continue in the evenings.

99% of health facility CFF respondents felt that opening times are convenient, and health facility staff concurred, adding that there is usually 24 hour emergency care / midwife services, but normal service delivery is until 2.30pm or 3pm and this is fine, as women generally come in the mornings.

Reaching the most vulnerable

For WGSS services, staff report that services are offered without discrimination but also recognise that *"people with special needs may find it difficult to reach centres"*. Others report simultaneously that programmes are targeted to the most vulnerable but that some particularly vulnerable groups – such as older people – are not targeted. One respondent highlighted Al-Mesalla Foundation as having a specific awareness programme for people with special needs and this is where some individuals can be referred to.

Health facility staff respondents reported that services are provided to the most affected and marginalised and that in general, the beneficiaries and the target areas are among the most vulnerable groups.

UNFPA implementing partners do have adolescent girls focal points (hired by the implementing partner and funded by UNFPA) and UNFPA has an adolescent girls technical manager position. UNFPA Iraq have adolescent girls indicators for outputs in the CPD. There is also a new project currently being launched, initially aimed at Iraqi nationals but planned to be extended to refugee populations, providing online support services for adolescents and targeting KRI and Baghdad.

UNFPA Iraq has a **people with disabilities** output in the CPD (number of disabled women and girls subjected to violence that have accessed the essential services package). There is also a target for ratio of people with disabilities in activities but the 2020 Annual Report acknowledges that this is not systematically reported by implementing partners.[83] In 2020, UNFPA Iraq has worked with its partners to target and report on persons with disabilities across youth, GBV, and SRH programmes.[84]

Youth centre staff acknowledge that the centres and activities are not prepared for people with special needs, particularly where activities are carried out in "caravans" which are not accessible for youth with physical disabilities. In addition, there is recognition that "the societal view affects them greatly": it is not just physical barriers to access for youth with disabilities, but also stigmatisation and cultural barriers.

WGSS staff report that some people with special needs access services at WGSS and that "we try to provide assistance to them as much as possible" but as with the youth centre staff responses, they confirm that a major obstacle is cultural / societal. Another major obstacle is that roads and paths leading to service units are inaccessible for those with physical disabilities, even if the centre itself is accessible.

Health facility staff report that many women with special needs access services.

COVID-19 – effects on accessibility, and UNFPA mitigation measures

Different service units reported different rationales for the impact of COVID-19 on access to services:

For youth centres, accessibility was impacted by COVID-19 based on:

- Fear of infection;
- Requirement to enter the labour market (as fathers had lost work);
- Trauma on losing family members to the disease.

For WGSS, accessibility was impacted by COVID-19 based on:

- the curfew put in place by authorities;
- the interruption of communication with beneficiaries;
- the fear of infection;
- the economic situation;
- the protection in the camp was suspended during curfew;[85]
- the increased difficulty in obtaining permits to enter the camps during the height of lockdown.

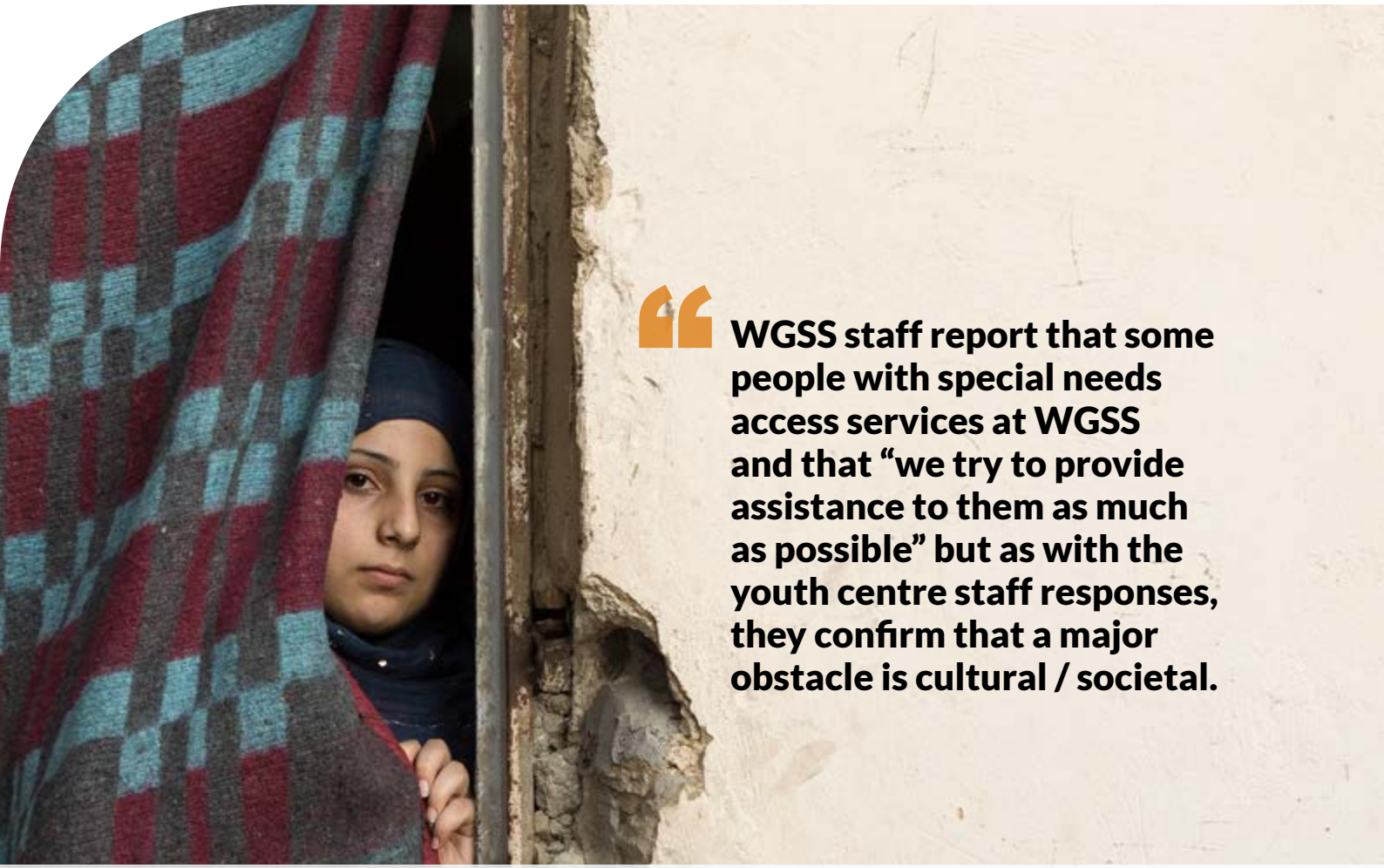
For health facilities, staff reported no real impact on beneficiaries accessing services although they did struggle to enforce compliance with mask-wearing and social distancing.

UNFPA Iraq has undertaken a number of measures to adapt the provision of services to the COVID-19 situation.

For youth centres:

- reduction of number of participants for any activity;
- commitment to social distancing and use of masks and gloves;
- providing awareness activities through social media applications;
- provision of online services.

83 UNFPA. 2019 Annual Report – Iraq. 2020
84 UNFPA key informants.
85 While not specifically stated, this report assumes this means that women and girls were more fearful of moving about the camp to access services.



WGSS staff report that some people with special needs access services at WGSS and that "we try to provide assistance to them as much as possible" but as with the youth centre staff responses, they confirm that a major obstacle is cultural / societal.

For WGSS:

- suspending group activities;
- commitment to social distancing and use of masks and gloves;
- allocation of specific tools and equipment for each participation during activities, and sterilisation between uses;
- reduction of field services;
- reduction of number of participants for any activity;
- providing awareness sessions about Coronavirus and how to prevent it; reducing the number of mobile teams;
- provision of remote GBV services.

Note, one respondent reported that awareness programs have stopped, especially those associated with the government as "they do not agree to provide online training and awareness".

For health facilities:

- provision of PPE;
- putting outdoor waiting chairs with consideration for spacing;
- reduction of working hours;
- reduction of the use of forms that were previously used by women.

EFFICIENCY

Staffing: Iraq respondents overall highlighted a general shortage of health staff, and because of COVID-19, more staff transferred to hospitals from health facilities and absences from staff either sick, isolating, or at high risk (such as pregnant staff).

Youth centres reported staffing is generally sufficient, although for COVID-19 there was a need for more outreach workers and those that could do training online.

WGSS reported the need for more staff in general, and for the COVID-19 situation, more mobilisers.

Training: In terms of received training, youth centre staff have received various trainings from UNFPA including peace-building, life-skills, and how best to provide educational and vocational training to young people.

In WGSS, staff have received a variety of training from UNFPA in PSS counselling and support, confidentiality protocols, remote case management (for COVID-19), and how to manage referral pathways. Staff request further or continued training on GBV IMS, GBV case management – and particularly more training on remote case management for COVID-19, and MHPSS counselling and protocols.

In health facilities, staff have received training on SRH and SRHR, GBV, abortion management and general case management. Health facility staff highlight the challenges in participating in training due to pressure of work. However, training that is consistently requested includes working with young adolescents (under 15 years old), working with those with special needs, working with children in prisons, updated family planning options and protocols and also project management during crises and proposal writing training.

Overall, all facility staff – Health facilities, WGSS, and youth centres, are requesting more training on infection prevention – especially related to COVID-19 measures, and in particular, a better understanding of COVID-19 and pregnancy. Furthermore, there is also a request for better online skills (i.e. Zoom training) to facilitate better virtual services and activities.

Supplies: For health facilities, it is reported that there is a general shortage of medicines and vaccines in Dohuk governorate and a lack of sufficient contraceptives in Erbil.[86] Also reported was some challenges with RH kits, both in terms of short expiry dates for some contents and inappropriateness for the context of other contents.

In youth centres, there were no gaps reported in supplies or equipment, and staff particularly highlighted the importance of dignity kits for adolescents.

Some WGSS staff reported a shortage of dignity kits and highlighted that the content could be improved in terms of quantity and a range of sizes for different items. Respondents reported that not all items within post-rape kits were useful, as any sexual violence survivor is normally referred directly to the hospital or the MSF clinic. Requirements for additional supplies for COVID-19 focused on communication supplies such as mobile phones and internet cards.

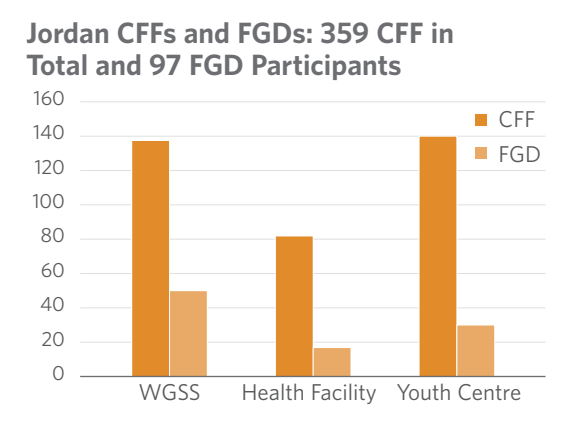
Challenges: Reported challenges include:

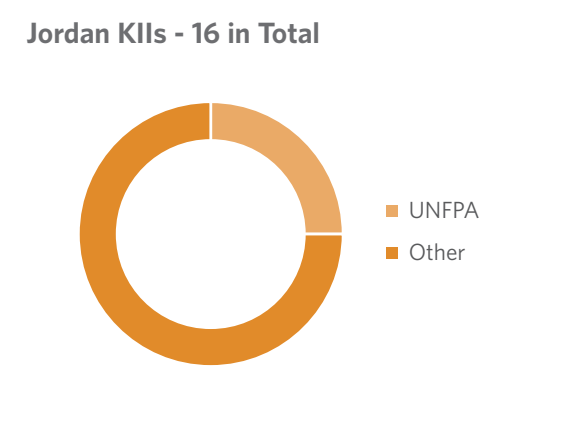
- WGSS: COVID-19 is the biggest challenge; no shelter in Mosul; lack of transportation for beneficiaries, requirement for IGA, especially during COVID-19 times;
- Health facilities: awareness of services is limited;
- Youth centres: lack of donor funding for youth, salaries not paid on time, and no increase in salary since 2015.

86 UNFPA key informants report that contraceptives have been supplied, but partners report this supply is insufficient for need in Erbil.

JORDAN

Figure 22. Jordan data sources





IMPACT

UNFPA Jordan provides support to Syrian refugees across three camps (Za'atari, Azraq, and the Berm) and in host communities, providing integrated SRH and GBV prevention and response services. UNFPA supports 18 WGSS, 7 in camps and four in host communities, and health facilities in the camps only. Jordan also supports a youth centre "A space for Change" in Za'atari camp, operated by Questscope and provides support to youth network coordination across Jordan. In 2015, the UNFPA Y-PEER Network was extended to Syrian youth. The maternal health clinic in Za'atari Camp is recognised as a "centre of excellence" and as a facility with zero maternal deaths, which delivers comprehensive quality SRH services. A number of Syrian refugees from outside the camp also accessed the clinic for deliveries.

UNFPA Jordan operates 19 community service delivery points – either comprehensive clinics or Women and Girls Safe Spaces (WGSS) – that are available to communities.

Within the youth centre in Za'atari young people from the age of 10 to 30 years old[87] access awareness programmes on reproductive and sexual health issues and gender-based violence. There is a 'Best of life programme' which builds youth capacities in a variety of areas and a community outreach programme, training youth on community communication methodologies. There is also an empathy (mental health support) programme. In addition, there are a variety of art and craft activities, sport, language and computer lessons, and a full library.

87 Note that the Syria Regional Response Evaluation in 2018 raised questions about the age range of 10-30 in the youth centre in Za'atari camp. 2. There are currently guidelines for working with and for youth in humanitarian settings being reviewed by IASC with the view to the guidelines becoming a formal endorsed IASC product: these guidelines recognise local differences in definitions but reinforced that the global definition of youth is 15-24.

For GBV services, in addition to the WGSS facilities, there is a hotline provided in 6 governorates, providing counselling for GBV survivors and more generalised PSS support. WGSS provides a variety of awareness raising courses, case management (psychological and social services) for GBV survivors, vocational training, and referral services.

The impact of services is high, as reported by beneficiaries themselves:

Figure 23. Ranking of importance of receiving services, from client feedback forms in Jordan

	Absolutely essential	Very important	Of average importance	Of little importance	Of no importance
 WGSS	77%	15%	7%	1%	0%
 Health Facility	46%	44%	9%	1%	0%
 Youth Centre	37%	53%	10%	0%	0%

WGSS FGD participants highlighted a number of important benefits of accessing WGSS, including the *"psychological comfort"* of the spaces; the change in daily routine and the alleviation of boredom; access to a diverse range of services for free; *"kind and gentle"* service providers; and friendship support.

> *"The centre is for us is like going to the park, and a place to relieve our stress."*[88]

Za'atari youth centre FGD participants highlighted that the youth centre is a safe place to learn, to read, to meet friends, and to stay safe.

> *"It's better to come here than stay in the streets."*[89]

> *"Whenever I am upset, I come here to play music so that I calm down. I feel comfortable when I come to the centre."*[90]

> *"I feel stronger for my experiences in the training courses."*[91]

88 WGSS FGD participant.
89 Youth centre FGD participant.
90 Ibid.
91 Ibid.

FGD participants were happy to suggest ideas for improvements. So, for example, health clinic beneficiaries suggested a list of services they were keen to receive – paediatric therapy, dental treatment, treatment for diabetes, and treatment for hypertension for men – none of which, of course, are SRHR services or necessarily within the mandate of UNFPA. However, it highlights the types of additional medical services beneficiaries are requiring. Furthermore, a common request was for free hand sanitiser since the pandemic started.

WGSS FGD participants were very keen on the sewing courses and suggested more of these courses could be run, with more sewing machines.

In one group, participants all requested specialised services for people with disabilities, and particularly men with disabilities – suggesting that there is still a confusion as to the primary and foundational purpose of a WGSS. However, women themselves requested that more male awareness courses were offered to their husbands, with regard to gender equality, which they believe would increase their safety at home. This highlights the confidence that women have in UNFPA and the idea is certainly worth pursuing but only within the parameters of understanding that WGSS spaces themselves should not be used for male awareness raising activities. Furthermore, it is unlikely that a short course of awareness raising sessions would significantly alter embedded male behaviour within the homes. However, again, it is a sign of confidence in UNFPA and partners that women are requesting interventions targeting their husbands.

Many beneficiaries highlighted that having remote (telephone-based) follow-up services would be useful and others highlighted a need for vocational courses that lead to income-generating activities, particularly for more vulnerable beneficiaries, such as those with disabilities. Childcare was another popular request, as was providing transportation support.

Some beneficiaries highlighted that all WGSS spaces (in the communities rather than the camps) should equally serve host community and refugee women and girls.[92]

Youth centre FGD participants requested more sports activities and more formalised education classes. Diversity in musical instruments, English language courses, with official certificates, and computers with access to the internet were also high on the list of requests.

Similar to the issue with male activities in WGSS, and contrary to global good practice guidelines, there was a request from (older) FGD participants for more activities for those over the age of 30.

With both the requests for male activities in WGSS and activities for older adults in youth centres, it is difficult for UNFPA to balance global good practice and UNFPA mandate responsibility with community demands. However, it is entirely incumbent upon UNFPA to do this and to adhere to the clearly stated constituency audience of UNFPA for different service units. WGSS exist to serve women and girls and youth-focused activities exist to serve youth.

UNFPA partners report that livelihood services shows the largest gap of all those offered. This is confirmed by the GBV IMS Task Force Annual Report in 2019 which highlights more than 68.5% of survivors were unable to access livelihood services due to unavailability.[93] Women themselves report that the most utilised WGSS services are psychosocial support, awareness sessions, and arts and crafts activities.

> *"Psychological support services and awareness programs through lectures because they help us to get information and provide us with new experiences and skills that we have not gained before, especially in dealing with our children and husbands and in providing care to ourselves. They also help us to relieve the stresses of daily life and feel confident and strong and able to make decisions in a safe and conscious way and get out of the circle of isolation and depression."*[94]

92 UNFPA Jordan staff confirm that this is the case and therefore there is a perception issue among beneficiaries.
93 UNFPA. Jordan GBV IMS Task Force Annual Report. 2019.
94 WGSS FGD participants.

For youth in youth centres, participants reported a wide range of activities as being favourites – sport, the library, learning English, computer courses, music, and art.

For health clinics, family planning services and antenatal care are reported as the two most important services for women to access.

COVID-19

UNFPA, service providers, and beneficiaries themselves report that everyone, women, girls, men and boys across all age groups are feeling greater stress and anxiety due to both the pandemic and the strict government lockdown response to the situation. A joint UNFPA, ECHO, IFH, Plan International report highlighted that 71% of respondents to their survey were worried about the pandemic, with Syrian refugees generally reporting higher levels of concern than Jordanian nationals, and other refugee nationalities (Sudanese, Egyptian, and Gazan) reporting even higher levels still. The concerns are both health and economic-related.

Women and girls report 50% less access to income-generating activities or material assistance than men and boys, with only 7% of adolescent girls reporting successful access compared to 24% of adolescent boys. In addition to health and economics, adolescents of both sexes are concerned about educational disruption. Jordanian adolescents (of both sexes) report higher levels of access to remote learning than their Syrian counterparts.

55% of adolescent girls reported increased household chores during the lockdown (including childcare of younger siblings) and fewer opportunities to meet with friends.

69% of survey respondents reported that domestic violence has increased due to COVID-19. However, the registered cases in GBVIMS reduced – highlighting that seeking help has decreased while violence has increased.[95]

The FGDs conducted for this assessment highlight that a number of youth stopped using youth centres during the pandemic, but many youth activities were able to be converted to online platforms.

For health clinics, there were no initial alternative plans for the health centres, but there was support from the government to facilitate follow-up of necessary cases. UNFPA report that some centres have business continuity plans in place.

In addition, health service providers reported that women are usually provided with three months' supply (for example, with the contraceptive pill) and this helped mitigate some of the negative impact. Women in general returned to health clinics quickly when they reopened after lockdown although there are fewer beneficiaries now than before lockdown.

WGSS services tried to provide as many services remotely as possible during the lockdown period. However, this did not stop COVID-19 adversely affecting WGSS beneficiaries in many ways; despite the increase in domestic violence, the government closed the Ministry of Social Development shelter and for other shelters, anyone working there had restricted movement based on government regulations. WGSS service providers mainly report that women have returned to the centre as soon as lockdown was lifted.

The vast majority of beneficiaries of all service units feel both safe and respected.

> *"Yes, I feel safe, because all of them are females, they are very nice, and most importantly, I am certain of complete confidentiality in the centre without any fear that my story would be told to other people."*[96]

95 All data from: ECHO UNFPA IFH Plan. Daring to Ask, Listen, and Act: A Snapshot of the Impacts of COVID-19 on Women and Girls' rights and sexual and reproductive health. 2020

96 WGSS FGD participant.

One health CFF response out of 82 reported feeling unsafe and two reported not feeling respected.

For youth, two out of 140 youth centre CFF responses reported feeling unsafe, with no-one reporting a lack of respect. For women and girls accessing services at WGSS, one out of 137 CFF responses reported feeling neither safe nor respected.

ACCESS

Youth centre staff respondents in Jordan highlight that there are no other centres in Za'atari which provide such a range of services offered to the specific youth demographic.

> *"Other centres have different services. But what is available in the centre here is not available anywhere else."*[97]

> *"We might find other centres, but the treatment here would be better and we feel comfortable."*[98]

> *"The way they treat us here is different than other places."*[99]

> *"The centre is special, but there are other services out there."*[100]

For WGSS services, staff report that there are other institutions present in the camps (Za'atari and Azraq) but not as integrated as the WGSS model with SRHR health services, GBV case management, PSS counselling, and educational and vocational courses for economic empowerment, together with referral services.

Outside of the camps, it depends on the location of the services as to whether staff and FGD respondents highlight whether there are other similar accessible services nearby. So for example, in some FGDs, beneficiaries stated there are no other similar services, but in others they referenced the Land of Human Beings organisation, Caritas medical services, The Princess Sumayyah Centre, IMC services, and UNHCR.

Za'atari camp health facility FGD participants highlighted that only the UNPFA-supported maternity clinic provides free quality SRH services.

97 FGD participant.
98 Ibid.
99 Ibid.
100 Ibid.

Figure 24. CFF respondents describing accessibility

	Easy	Moderate	Difficult
 **WGSS**	60%	29%	11%
 **Health Facility**	33%	36%	33%
 **Youth Centre**	51%	41%	8%

For health facilities, approximately a third of CFF respondents reported easy access. In different FGDs, the majority of participants referenced ease of access (9 out of 10 in one FGD, and 6 out of 7 in another). For those FGD participants that did highlight challenges (for themselves or for others), and through CFFs, the most common problems were transport-related (lack of transport or cost of transport), and lack of childcare.

Some WGSS FGD participants confirmed the CFF responses, as the majority report easy access to the centre, but others offered a number of challenges including weather conditions (both too cold and too hot); one highlighted that her husband did not agree with her coming; childcare issues, and lack of transportation / expensive transportation.

Youth centre FGD participants almost all reported ease of access to the facility although some reference COVID-19 as a challenge and some referenced school or work making it hard to find the time to come to the centre. For others, the heat in the summer and the mud in the winter prove problematic. One referenced sexual harassment on the way:

> *"The guys harass us verbally if we walk through the market."*[101]

This was also supported by CFF respondents.

In terms of awareness of services, beneficiaries of different service units receive information about the services in different ways. For WGSS participants, it is mainly neighbours and family, word of mouth, and referrals. For health facility beneficiaries it is neighbours, family, and word of mouth. For youth centre beneficiaries, it is friends and word of mouth.

101 Youth centre FGD participant.

Figure 25. Convenience of opening hours

CFF respondents reporting opening hours are not convenient

WGSS

1%

Health Facility

4%

Youth Centre

6%

Youth FGD participants in Za'atari confirmed the CFFs, which reported that 94% of beneficiaries found the times convenient: many highlighted the fact that it can be difficult to run activities in the evenings anyway (opening times are 8-4) due to camp policies.

WGSS FGD participants and WGSS staff confirmed women and girls prefer morning sessions – although it was also stressed that during school vacations women prefer the option of having evening sessions and during Ramadan all beneficiaries, women and girls, prefer the option of evening sessions. Girls reported that they do attend the centre after school.

Za'atari health facility FGD participants all expressed that hours are convenient and also that they appreciate the UNFPA hospital staying open later than the government health centre that closes at 1.30pm.

Reaching the most vulnerable

WGSS staff concede they may be certain groups for whom there are no targeted activities: for example, they report that many older women (those over 60) complain that there are no specific activities for them, nor can they participate in the activities on offer because of their age.

WGSS participants all highlighted the continuing need for additional activities specific to **adolescent girls,** including economic empowerment courses for girls, and educational and psychological services for girls.

Vis à vis people with disabilities, a global evaluation reported that in Jordan:

"In terms of disability inclusion, the implementing partners operating in the camps and host communities have received disability inclusion training so that GBV services are responsive to people living with disabilities. The consideration of disability is important to applying an intersectional approach to gender equality, as women and girls who have a disability are at higher risk of GBV. A further measure in disability inclusion is the adaptation of the physical space of the youth centre in Za'atari Camp to be disability-friendly, however, as reported in the Syria Response evaluation, the more significant difficulty for youth with disabilities is transport to the centre."[102]

At the same time, Jordan GBV IMS data shows that people with disabilities are three times more likely to face physical, sexual, and emotional violence than people without disabilities. Women with disabilities are ten times more likely to experience sexual violence.[103] Therefore the importance of ensuring accessibility by those with disabilities is critical.

102 UNFPA. Evaluation of UNFPA support to gender equality and the women's empowerment across development and humanitarian settings 2012-2020. Jordan case study: country evidence table. 2020.
103 UNFPA. Jordan GBV IMS Task Force Annual Report. 2019.

Jordan GBV IMS data shows that people with disabilities are three times more likely to face physical, sexual, and emotional violence than people without disabilities. Women with disabilities are ten times more likely to experience sexual violence.

In Jordan, UNFPA drafted a multiyear office workplan on disability inclusion through a participatory approach with colleagues and with the inputs from PWD themselves. The workplan aims to work towards office accessibility and capacity-building on how to work with and for PWD together with implementing partners. Additionally, the office received a capacity-building on the UNFPA Global Guidelines on SRHR and GBV services for women and young people with disabilities. UNFPA Jordan also continued to ensure the participation and inclusion of PWD in different events, campaigns, youth groups and youth networks in the different programmes, and started the process of hiring a consultant to review the work plans for 2021 with partners. They also gave technical and strategic recommendations on how to operationalise the disability inclusion work plan for the office and how to create an enabling environment where persons with disabilities are included across programmes and departments. The GBV programme supported a training for service providers in 2020 to deal with survivors of GBV and monitor the reach of PWD with specific indicators on the workplan.

Youth centre staff confirm that youth with special needs are taken into account within the programmes and that the youth volunteers within the centre are very proactive in reaching out to youth with disabilities. This was supported by one FGD participant: *"It helped us a lot. My sister is deaf and mute, and she benefitted a lot in the courses with the help of the facilitators. She became much better."*[104] However, it is also acknowledged that a big challenge is getting to the centre, with the need for wheelchairs (and the unsuitability of terrain for wheelchair) or an escort for those that are blind, and these challenges persist.

Health facility FGD participants highlighted that there should be more services for people with disabilities, and more equipment such as elevators.

Within Jordan more broadly, Ministry of Health respondents report that sexual and reproductive health services are provided to all women and girls without any discrimination, including Syrian refugee women and girls, but there is still a weakness in dealing with those with special needs based on physical access, and lack of knowledge among service providers of sign language for those that are deaf etc.

104 Youth FGD participant.

UNFPA and IP GBV staff report that there are some WGSS that are well sensitised to working with particularly vulnerable individuals, such as the elderly or those with special needs, but there are still access difficulties for people with physical disabilities.

WGSS FGD participants highlighted that there should be more services for people with disabilities and that both physical accessibility and societal norms prove to be barriers for access.

COVID-19 – effects on accessibility, and UNFPA mitigation measures

Different service units reported different rationales for the impact of COVID-19 on access to services:

Youth centre staff and FGD participants all reported a strong desire to return to face-to-face services as soon as possible.

However, UNFPA report that plans for 2020 for youth were of a more national strategic level, and COVID-19 has interrupted their progress, as it is difficult to work with the government remotely rather than face-to-face.

For WGSS, accessibility was primarily impacted by COVID-19 based on:

- fear of infection (particularly those with chronic diseases and respiratory diseases);
- the closure and isolation of many areas and service centres by the Government which significantly impacted on accessing services.

For health facilities, staff reported no real impact of COVID-19 on beneficiaries accessing services although they did struggle to enforce compliance with mask-wearing and social distancing.

Figure 26. CFF respondents who reported stopping access to services due to COVID-19

CFF respondents who stopped accessing services due to COVID-19

WGSS	Health Facility	Youth Centre
50%	45%	60%

UNFPA Jordan reported changing a number of modalities in order to adapt services to the new pandemic situation. UNFPA Jordan actually report an MoU with Zain and had anyway previously been working with women to use mobile phones – and during the pandemic, UNFPA added specific messaging that went out to women via the mobile phones. Implementing partners quickly established more hotline capacity and it is reported that even when physical services were re-established, the hotlines were kept open as some women preferred this.

In addition to this, specific service units undertook the following:

Youth centres:

- provision of remote services;
- decreasing number of participants in each activity.

WGSS:

- reducing the number of beneficiaries in one place;
- ensuring all employees had computers, mobile phones, internet, and could work from home;
- using an electronic app for referral pathways;[105]
- disseminating contact numbers to provide support through social media and WhatsApp;
- mitigation measures in centres (social distancing, wearing masks, hand sanitiser).

EFFICIENCY

Staffing: youth centres report adequate staffing but also highlight the continuing need to provide new and diversified services which would require more youth educators. Since COVID-19, the number of youth volunteers in Za'atari has increased. WGSS staff report a consistent need for increased staff, but with no additional change to this due to COVID-19. Health facility staff were reported as adequate.

Training: For all service units in Jordan, staff report receiving training in CMR, remote support, and COVID-19 awareness. In general, there is a request for more training on addressing cyber harassment, which is a growing problem in Jordan.

Youth centre staff have particularly received training in GBV, referral pathways, media and communication, self-care, WhatsApp engagement with youth, and protection measures for COVID-19. Youth centre staff request more training on working with youth in creative ways, SRHR training, and communication skills.

WGSS staff have received training in project management, case management, working with people with disabilities, specific training in the IRC technical package, and delivering services during the COVID-19 pandemic. IP staff for WGSS activities requested more training on resource mobilisation and grant management activities – proposal writing and report writing as well as some specific ideas for activities, such as art therapy.

Health staff particularly request more training on managing cases of sexual assault, PSS support, training and on violence in all forms.

Supplies: For health facilities (in camps only) respondents report that everything they require is available within the MOH outside of camps and there are good referral pathways in place. In camps, there are RH kits and hygiene kits. Shortages are reported in more ancillary items, such as computers and printers.

In youth centres, there are no shortages reported, but staff highlight the fact that there is insufficient budget for the activities planned and particularly in terms of COVID-19, where violence and stress has increased, there is a requirement for increased funding

WGSS staff report no shortage of supplies, however rehabilitation of some centres is required such as fire safety systems. Like health facility staff, they report a shortage of computers – and mobile phones – particularly during COVID-19 times with increased remote / virtual provision of services. No respondents reported any further shortages. Furthermore, COVID-19 has highlighted the lack of dry (covered) outdoor space for many WGSS which is important for providing safe services during the pandemic.

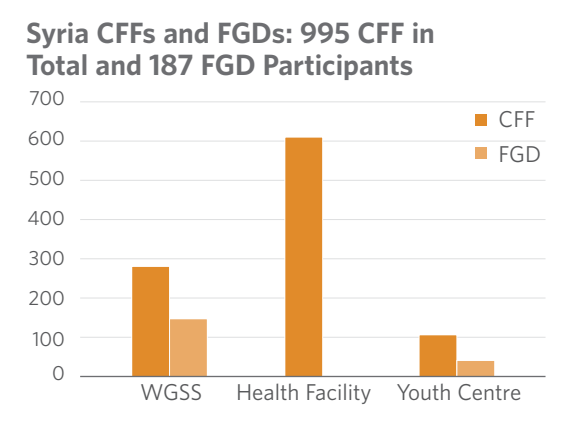
Challenges: Reported challenges include:

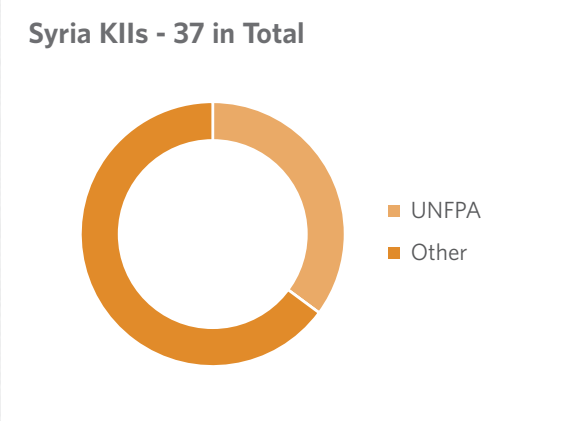
- In general, raising awareness of GBV; continuous training on GBV, PSS based on continuous staff turnover; the COVID-19 pandemic *and* the government lockdown response has been the biggest challenges; and the lack of cash assistance remains a challenge.
- For WGSS: funding being limited and government approvals are significant challenges;
- For youth centres; funding is a general challenge; and entry and exit to and from camps is a further challenge.

105 This is the Amaali application which is a phone application UNFPA and UNHCR worked on for referral pathways: it was updated with an emergency section during COVID 19

SYRIA

Figure 27. Syria data sources





IMPACT

UNFPA Syria manage 47 WGSS, 86 primary health facilities, 76 mobile clinics, and 9 youth centres. Services vary across the different facilities.

The Syria RH programme supports 25 different implementing partnership for running the static and mobile health facilities. The primary RH services provided are ANC, PNC, PSS, and family planning. 47 WGSS and associated GBV mobile teams provide a variety of services and activities to women and girls. These include vocational courses, psychosocial support, awareness raising sessions, health and social lectures, art, crafts, sport, and language courses. The Syria youth programme has five pillars, spanning capacity-building of youth (such as life skills and vocational courses); access to information on healthy lifestyles; youth leadership and civic engagement' access of young people to livelihood opportunities; and provision of services, mainly PSS.

The positive impact of accessing these services is self-reported by beneficiaries as being high:

Figure 28. Ranking of importance of receiving services, from client feedback forms in Syria:

	Absolutely essential	Very important	Of average importance	Of little importance	Of no importance
 **WGSS**	56%	36%	8%	0%	0%
 **Health Facility**	57%	38%	4%	1%	0%
 **Youth Centre**	20%	52%	28%	0%	0%

WGSS FGD participants reported that accessing services *"lifted their spirits"* as well as developing new skills, increasing confidence, and meeting new people.

> *'Expanding my imagination and I got to know myself and I changed 180 degrees and my thinking and awareness changed – I was encouraged to finish my education and I finished the 9th grade and I will finish my high school diploma because this space encouraged me.'*[106]

> *'I started knowing right from wrong. We never had awareness because of our society.'*[107]

> *'My husband never allowed me to socialise but when I came here, I became motivated and I had support so I started knowing how to express myself and how to deal with my kids – I became stronger in discussions and I have new vocabulary and I became more confident.'*[108]

Adolescent girls in particular in Syria highlighted the increase in self-confidence that came from accessing adolescent girl activities within WGSS.

Youth FGD participants reported self-development, and courses such as graphic design, as being hugely beneficial to their welfare. They reported feeling more self-confident and specifically enjoy the issue of civic engagement and giving back to their communities. Youth report that accessing the centre boosts their relationships, their knowledge, their social interaction, and their confidence to speak about problems and solutions.

106 WGSS FGD participant.
107 Ibid.
108 Ibid.

"The centre is giving us something positive, and we are spreading this positivity around."[109]

FGD respondents were happy to suggest areas for improvement. Youth centre FGD participants highlighted simply increasing the scope and number of activities as well as increasing the number of buses for transportation and, within certain FGDs, requesting that the initiatives proposed by youth themselves are considered more seriously.

WGSS FGD participants requested additional toys in the childcare rooms / nurseries as well as literacy courses and language courses – this was specifically highlighted by female youth and adolescent girls. There was also a request for hardware after courses: specifically sewing machines after finishing a sewing course and in general, more linkages to income-generating opportunities. Sewing is a very popular activity across all age groups within the WGSS, as are life skills / awareness-raising sessions and, where offered, English and/or computer courses.

This is similar for youth centres, although sports replaces sewing as one of the most important activities.

For health facilities, almost all respondents prioritise family planning and ANC as the most important services they have received.

COVID-19

In Syria, UNFPA and partners have witnessed an increased risk of GBV, particularly domestic violence, due to the COVID-19 pandemic – blamed specifically on the containment measures and the worsening economic situation. Families were restricted in their homes, with many men being daily workers and unable to earn money, so the combination of the two issues – increased frustration and lockdown inside exacerbated risks of violence.

UNFPA conducted a series of webinars on remote service provision, which, while useful, have not been able to solve all challenges. For example, UNFPA report there is still a problem with disclosure over the phone, with so many women having built up a significant level of trust through face-to-face time in WGSS, and therefore understandably struggling with telephone modalities instead. Referrals became problematic in many places, as many service points were closed.

WGSS FGD participants reported a range of impacts, with some saying they stopped accessing the WGSS services for up to three months, and others (particularly adolescent girls) reporting that they still accessed the WGSS, but used hand sanitiser, wore masks, and socially distanced.

Youth were easily able to access their courses (such as English language courses) online but missed some of the theatre and sports activities they were used to participating in.

UNFPA report that many of their health facilities actually saw an increase in beneficiaries, because of other service points which had temporarily closed, while other health facilities saw a slight decrease.

On a more positive note, UNFPA Syria is trialling the production of face masks in the WGSS to distribute to service centres. In addition UNFPA report that there was a number of new and creative modalities implemented because of the pandemic, and some of them are helpful, such as remote training, WhatsApp groups, Facebook pages for information etc. It allows for providing alternative channels to reach people and there is a sense that maybe these channels can remain in addition to the more traditional ways of working when the pandemic is over.

All WGSS CFF respondents reported feeling safe with 2 out of 280 reporting not being respected. For health facilities, 2 out of 608 CFF respondents reported not feeling safe and 4 reported not feeling respected. All youth centre CFF respondents (107) reported feeling both safe and respected.

109 Youth centre FGD participant.

ACCESS

Syria is, of course, a challenging context with several crises occurring across the country at any one time and the destruction of health and social facilities over the last nine years has resulted in a clear criticality of UNFPA supported health facilities, WGSS, and youth centres. Certainly the UN system as a whole is a key actor for provision of services, with UNFPA having a logical niche within that system.

For youth services, UNICEF has various adolescent development and participation (ADAP) programmes operating across the country but their interventions focus more on life skills and general development, while UNFPA-supported centres focus on SRHR and GBV. Other UN agencies, such as UNHCR, have some GBV prevention and response services and UNICEF also has interventions that integrate GBV and child protection services. However, for more health-related SRHR services, UNFPA is quite unique. FGD participants confirm the uniqueness of all UNFPA-supported services.

Many WGSS FGD participants reported that while other similar services are available, none of them are free.

> *"Before this centre, I searched a lot and especially for a centre that gives services for free because I cannot afford to pay. There was a development centre, but I couldn't take a computer course in it, so I left. It was not free, and does not have the services we want."*[110]

Younger participants added that the mosque might represent a similar safe place to go, but that they would not receive the same services or participate in the same activities there.

A couple of participants highlighted both their own and their families' trust in the WGSS centres:

> *"My husband trusts where I am going and he trusts the centre, but he wouldn't trust any other place."*[111]

> *"My daughter would stay at home. I wouldn't feel good."*[112]

Finally, one FGD highlighted why it is so important to keep WGSS for women and girls only:

> *"We would not go to another centre because it would be mixed gender. But here we are comfortable."*[113]

For youth centre participants, some highlighted places they used to go (such as municipal venues) before discovering the UNFPA-supported centres. They all confirmed other centres do not have the range of services and activities offered within the youth centres or that they are not free.

One young person with disabilities reported that they:

> *"I used to go to the Hearing and Speech Impaired Children Association, before coming to Nour Association, but Nour Association has many services that other centres do not have."*[114]

In regard to health facilities, FGD participants reported that before the COVID-19 pandemic there were other centres that provided similar services but not for free. Furthermore, there are government centres affiliated with the Ministry of Health that provide the same services, but the procedures and bureaucracy there is complicated.

110 WGSS FGD participant.
111 Ibid.
112 Ibid.
113 Ibid.
114 Youth centre FGD participant.

Figure 29. CFF respondents describing accessibility

	Easy	Moderate	Difficult
 **WGSS**	40%	32%	28%
 **Health Facility**	69%	21%	10%
 **Youth Centre**	50%	44%	7%

WGSS FGD participants had a range of responses with regard to ease of access, mirroring the CFF responses which were split quite evenly across easy, moderate, and difficult. One reported having to take two service cabs to reach the centre which was both lengthy and costly. A respondent with disabilities reported having difficulties with transport to access the centre. Others reported easily accessing on foot or on micro buses. CFF responses mainly highlighted transport (lack of or cost of) as main challenges to access. Girls in some WGSS FGDs and some youth highlighted a lack of free time or household chores as a barrier to access.

> *"My parents don't allow me to go because it is far from home, and only if I finish the house errands."*[115]

A few participants highlighted the preference for having trainers come to their homes rather than them coming to the centres, which would be uneconomical and inefficient, as well as missing the foundational purpose of group training and learning together. However, it is important to note how this aligns with remote modalities employed within COVID-19 times for those who prefer not to attend a centre.

Almost all youth FGD participants agreed that access was easy, although some reported it took up to an hour on micro buses, particularly because the centre opens at 3pm, which is peak traffic time. Youth with disabilities particularly highlighted transportation difficulties.

Health facility CFF respondents mostly highlighted transport issues (lack of or cost of) as challenges to access.

In terms of awareness of services, beneficiaries of different service units receive information about the services in very similar ways: for all beneficiaries, neighbours, family and friends, word of mouth is the most common way they hear of services. Two WGSS FGD participants reported that they saw a Facebook advertisement.

115 WGSS adolescent girl FGD participant.

Figure 30. Convenience of opening hours

CFF respondents reporting opening hours are not convenient

WGSS	Health Facility	Youth Centre
11%	2%	3%

WGSS FGD participants mirrored the CFF responses which demonstrate 89% of youth find the opening hours convenient. They added that there are two options for sessions in some centres to choose from which they appreciated. Some had challenges with childcare and some youth reported that the hours clashed with university lectures.

Youth FGD participants all reflected the CFF responses (which demonstrated 97% of youth find the hours convenient) although some highlighted that in winter it becomes more difficult because it gets dark earlier.

Health facility staff reported the same as the CFF responses, which reflected a 98% satisfaction rate with opening times. The times are suitable for beneficiaries.

Reaching the most vulnerable

In Syria, UNPFA has clear classifications of vulnerability, which include adolescent girls, women in female-headed households, rural women, and those with disabilities. Geographically, the UN system in Syria has annual severity rankings for each governorate to help guide focus.

For WGSS, UNFPA report deliberately not having any particular activities for women and girls with disabilities, or women who the head of household, to avoid stigma. Instead, all women and girls are encouraged to participate in group activities and case workers have individual sessions to identify special needs. UNFPA Syria report trying as much as possible to ensure WGSS spaces are disability friendly.

Many WGSS FGD participants highlighted their own vulnerable status and how welcome they have felt – particularly those that are widowed or divorced.

Adolescent Girls

In Syria, overall, while adolescent girls in WGSS FGD highly appreciated the services they receive, it was difficult to establish how many activities were specific for adolescent girls. Adolescent girls did specifically highlight the increase in self-confidence that came from accessing activities within WGSS.

Health facility staff reported targeting girls and women from the age of 14 to age 50, with a strong focus on adolescent girls, and young women married at a young age.

Disabilities

UNFPA report that the list of criteria for assessing WGSS or clinics includes disability aspects, confirming during 2020 that all activities were moved to ground floor, and facilities have started to include ramps and toilets for people with disabilities where possible in some centres.

Some WGSS FGD participants confirmed that centres are welcoming to women and girls with disabilities:

> *"The association is open for everyone. Even if they were on a wheelchair, they would give them assistance. A girl on a wheelchair could come to the sowing course for example, or the recycling or hairdressing course."*[116]

> *"I don't think there is a problem. A person [with disabilities] can come, succeed and be brilliant and there are many such stories."*[117]

Many participants emphasised that it would depend on what type of disability. Other FGD participants strongly confirmed the lack of services for people with disabilities and this was a clear differentiation between FGDs in different WGSS.

In youth centres, FGD participants reported that services are suitable for most groups with *"some exceptions such as widows, or older males"* and participants suggested putting efforts into attracting these groups more, saying that the notion of *youth* centre perhaps needs to be more clearly articulated.

For health facilities, UNFPA report that people with special needs are integrated in all services and activities. Health facility staff report that many people with disabilities are initially not aware of the services available but through outreach in the community and through specialised institutions they are contacted and introduced to the services. There are no internal physical obstacles in the facilities, but the external obstacles (roads, transport issues etc) remain.

COVID-19 – effects on accessibility, and UNFPA mitigation measures

Different service units reported different rationales for the impact of COVID-19 on access to services:

For youth centres, accessibility was impacted by COVID-19 based on:

- fear of infection;
- some people returned to villages;
- group activities were forbidden;
- concern about the mitigation measures put in place in the youth centre (reported as being unsure how sterilised the centre could be);
- forbidden by parents to attend.

For WGSS, accessibility was impacted by COVID-19 based on:

- fear of infection;
- lack of transportation during the peak of the pandemic;
- for younger women and girls, the fear of passing the infection onto family members;
- for adolescent girls, parents preventing them from coming based on fear of infection.

Health facilities staff reported no significant impact on beneficiaries accessing services with some facilities reporting a small initial decrease in numbers which then soon resumed. Others, in fact, reported an increase in numbers during the pandemic, with only a subsequent decreases when schools and universities re-opened. Further, health staff report mobile teams continued to operate.

116 WGSS FGD participant.
117 Ibid.

Figure 31. CFF respondents who reported stopping access to services due to COVID-19

CFF respondents who stopped accessing services due to COVID-19

WGSS

46%

Health Facility

53%

Youth Centre

54%

UNFPA Syria put multiple measures in place for COVID-19 in a staggered and coherent manner, including:

Immediate response

- using social media platforms to conduct both GBV and COVID-19 awareness activities;
- establishment of WhatsApp groups to maintain social networks for WGSS beneficiaries;
- remote phone and WhatsApp provision of GBV case management, psychological first aid, individual counselling, and psychosocial support;
- Virtual provision of vocational trainings through online platforms. Production of short video messages on GBV, COVID-19, the effects of isolation on households and the increase of domestic violence during this time. Integrating mobile GBV/SRH services provision while minimising the number of individuals served in one session, therefore applying social distancing to ensure COVID-19 infection mitigation measures.
- Maintaining individual face-to-face GBV case management in the WGSS' with staff rotation of one person per day.

Continued longer-term response:

- Arabic language adaptation and regional contextualisation of the yet-to-be-launched on-line GBV risk mitigation training package (targeting all sectors) and creation of the online platform;
- Facilitation (in Arabic) of the on-line GBV mainstreaming training open to humanitarian actors in Syria.
- Development, in Arabic, of the first-ever self-paced e-learning course "IASC Guidelines for Integrating GBV Interventions in Humanitarian Action";
- Preparation and delivery of a series of webinars, in Arabic, targeting GBV service providers, on safe and ethical remote GBV service delivery;
- Development of a package (Arabic) of one pagers on remote GBV service delivery targeting UNFPA GBV service providers;
- Provision of remote technical support and supervision for UNFPA implementing partners based on needs;
- identifying and remotely providing online training for frontline non-GBV actors on Psychological First Aid (PFA) and providing GBV pocket guides with information on basic communication skills and referrals in case of disclosure of GBV incidents during their interaction with the communities.[118]

118 UNFPA. Syria Country Office Covid-10 gender-based violence response. 2020. In addition to this, FGD participants of both WGSS and youth centres highlighted social distancing, mask wearing, and hand sanitising measures in place in centres, together with more online activities and fewer numbers in group activities.

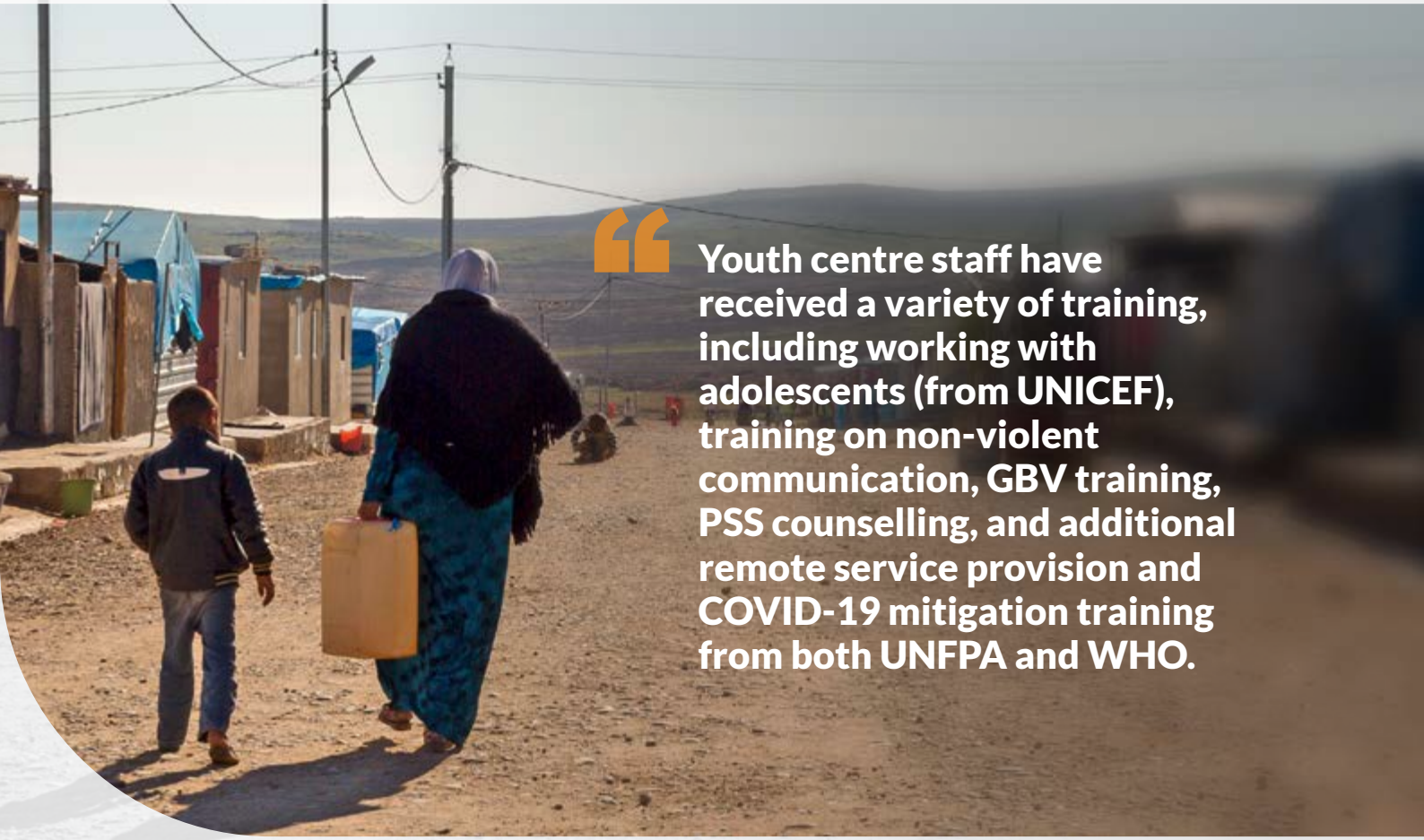
EFFICIENCY

Staffing: One youth centre reported a need for an additional staff member for report writing but other youth centres generally reported adequate staffing, and no additional staffing needs due to COVID-19.

Generally no gaps were reported for WGSS except the need for an additional psychiatrist in one location and an additional case manager in another. No additional staffing needs were reported due to COVID-19.

Health centres reported no gaps in staffing and no change due to Covid19.

Training: In general, staff request more in-depth training on an overall COVID-19 strategy to ensure both service providers and beneficiaries are protected by PPE (both equipment and training on proper use of equipment. WHO has conducted a series of online training on this and provided updated COVID-19 SOPs, which has been highly appreciated.



> **Youth centre staff have received a variety of training, including working with adolescents (from UNICEF), training on non-violent communication, GBV training, PSS counselling, and additional remote service provision and COVID-19 mitigation training from both UNFPA and WHO.**

Youth centre staff have received a variety of training, including working with adolescents (from UNICEF), training on non-violent communication, GBV training, PSS counselling, and additional remote service provision and COVID-19 mitigation training from both UNFPA and WHO. Youth centre staff requested more communication skills training, also training on provision, services to those with special needs (such as people with disabilities), more GBV training, training on specific activities such as interactive theatre, proposal writing training, and ongoing COVID-19 awareness and protection including support with work tools for remote / virtual service provision.

WGSS staff reported that they only received training on PSS counselling. WGSS staff cite ongoing GBV training needs, based on high turnover of staff, and then specifically for COVID-19, remote PSS counselling, training on addressing short and long-term effect of the pandemic, computer, internet, and online platforms (i.e. Zoom) training.

Health facility staff reported receiving training on GBV, PSS support to survivors, domestic violence, gender, and specifically for COVID-19, RH online and general COVID-19 adaptation, protection and prevention. For health facility workers, topics for training needs included training on various protocols for services, training on social norm and behaviour change work, training on PSS support basic principles, training on working with people with special needs, reaching the most vulnerable ("neediest") groups, and lastly, how to provide safe services during the COVID-19 pandemic.

Supplies: In general, staff report having sufficient supplies and highlight the benefit of dignity kits and particularly those specific to adolescent girls. Youth centre staff have highlighted the need for laptops and mobile phones during the COVID-19 pandemic.

Staff in WGSS have reported that they do not always have all the supplies they would like for all activities.[119] A new activity which has started across multiple WGSS is producing masks based on guidelines that UNFPA has provided, and starting with a pilot project on this in Homs. During the pandemic, there has been a shortage of quality masks and hand sanitiser.

In health facilities, respondents initially reported no shortage of supplies, but then staff highlighted the challenges currently with the exchange rate for the Syrian pound vis à vis allocated budget lines, which has resulted in shortage of contraceptives and vitamins. Facilities have RH kits 3 and 5 for family planning and STI treatment, but reported that not all contents are appropriate. Post-rape kits are available in clinics. During the pandemic, there has been a shortage of quality masks and hand sanitiser.

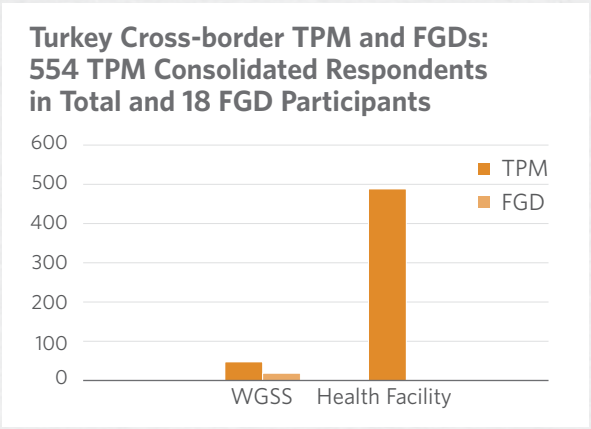
Challenges: Reported challenges include:

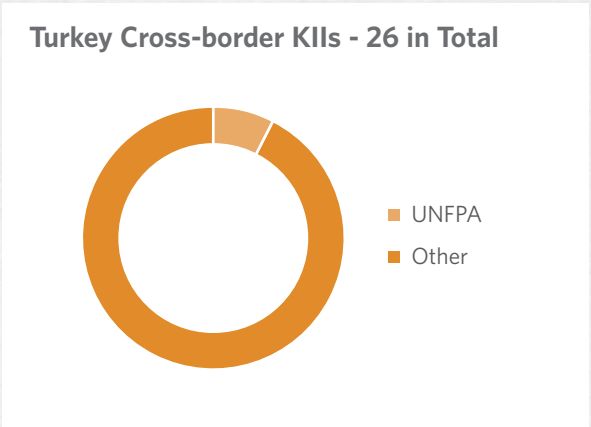
- In general: requirements for official approvals for activities and services; COVID-19 operational challenges in relation to logistics, containment measures, curfews, movement restrictions and working remotely; and M&E challenges related to COVID-19;
- For WGSS: challenges include lack of transportation / cost of transportation to centres; economic difficulties for beneficiaries and lack of cash assistance; communication difficulties between offices;
- For Health facilities: staff report a challenge being a necessity to work with men on family planning issues; local authority control; limitations of the referral system; lack of a private room when doing outreach services; unsafe abortion (1 respondent only;) lack of medicines for chronic diseases such as diabetes;
- For youth centres: funding remains a challenge; lack of vocational training for youth; lack of internet, disrupted and unreliable internet and lack of computers; and some youth centre staff reported that working within UNFPA mandate areas limits the activities that they work on.

119 there was no further clear information on exactly what additional supplies would be required and for which activities.

TURKEY CROSS-BORDER

Figure 32. Turkey Cross-border data sources





IMPACT

In 2014, the Whole of Syria (WoS) approach was introduced across the United Nations, authorised initially by UN Security Council Resolution (UNSCR) 2165 (2014), which allowed cross-border humanitarian assistance from Iraq, Jordan and Turkey. Successive UNSCRs extended and adapted this, eventually reducing to cross-border assistance from Turkey only. The most recent UNSCR resolution adopted on 10 July 2533 (2020), extends cross-border aid from Turkey for another year, but reduced down to one crossing point only.

UNFPA currently provides services through 43 service delivery points in northwest Syria, including BEmOC health facilities, CEmOC health facilities, mobile clinics, and WGSS facilities.

The health facilities provide a different range of needed services, moving from more basic PHC and RH services provided by mobile clinics to comprehensive services including caesarean sections in CEmOC hospitals.

WGSS centres provide a range of activities for women and girls from 9 upwards[120] which include: awareness raising sessions; life skill sessions; case management; referrals; and vocational, educational and arts and crafts courses such as computer, languages and sewing courses. There are also sport and leisure activities. 10 out of 17 centres have a midwife or nurse to facilitate the Young Mothers Club activities. The Young Mothers Clubs provide health awareness for reproductive and sexual health and

120 Service provider respondents highlighted the age range of 9-60 although UNFPA staff confirmed women of all ages are welcome.

psychosocial support to adolescent and youth mothers in addition to adopting a collaborative approach with influential community leaders including religious leaders, local councils and teachers with the objective of transforming negative societal norms that hinder a rights-based approach to adolescent SRH . Dignity kits are distributed in the communities through outreach teams.

Impact of services, as reported by FGD participants, is high.[121] All participants across all three demographic groups – girls, older people and women with disabilities – unanimously agreed that the impact of accessing WGSS services was positive.

> *"I can't wait till morning comes so that I go to the centre."*[122]

> *"I cope with my husband in a better way and I play with my children, and that is all thanks to the sessions that I attend here."*[123]

Ideas to improve WGSS include more sewing and other home economic courses such as cooking, but many FGD participants reported nothing needed to change, they are very satisfied with what is provided.

> *"There is no better centre than this one. Even the way they receive us is very nice."*[124]

TPM reports highlighted that there were positive reviews across WGSS and health facilities. All centres offered transportation services for beneficiaries who struggle to access the centres but also with priority given to people with disabilities. WGSS centres offer childcare services to beneficiaries and have hired full-time staff to cover childcare responsibilities. No significant negative feedback was given on access to the centre. The referral pathways, case management, and PSS services are all available and free of charge. All feedback on staff behaviour and quality of services was either considered satisfactory or very satisfactory.

Most commonly cited responses for the most useful services for GBV prevention were awareness activities around GBV. The most useful activities for empowerment mentioned by respondents were life skills and vocational trainings. For creating a sense of healing and security, PSS services and activities were identified as the most relevant and useful activities.

FGD participants highlighted similar preferences for psychosocial support, but also for girls in particular, hairdressing, sports, handicrafts, and recreational activities.

COVID-19

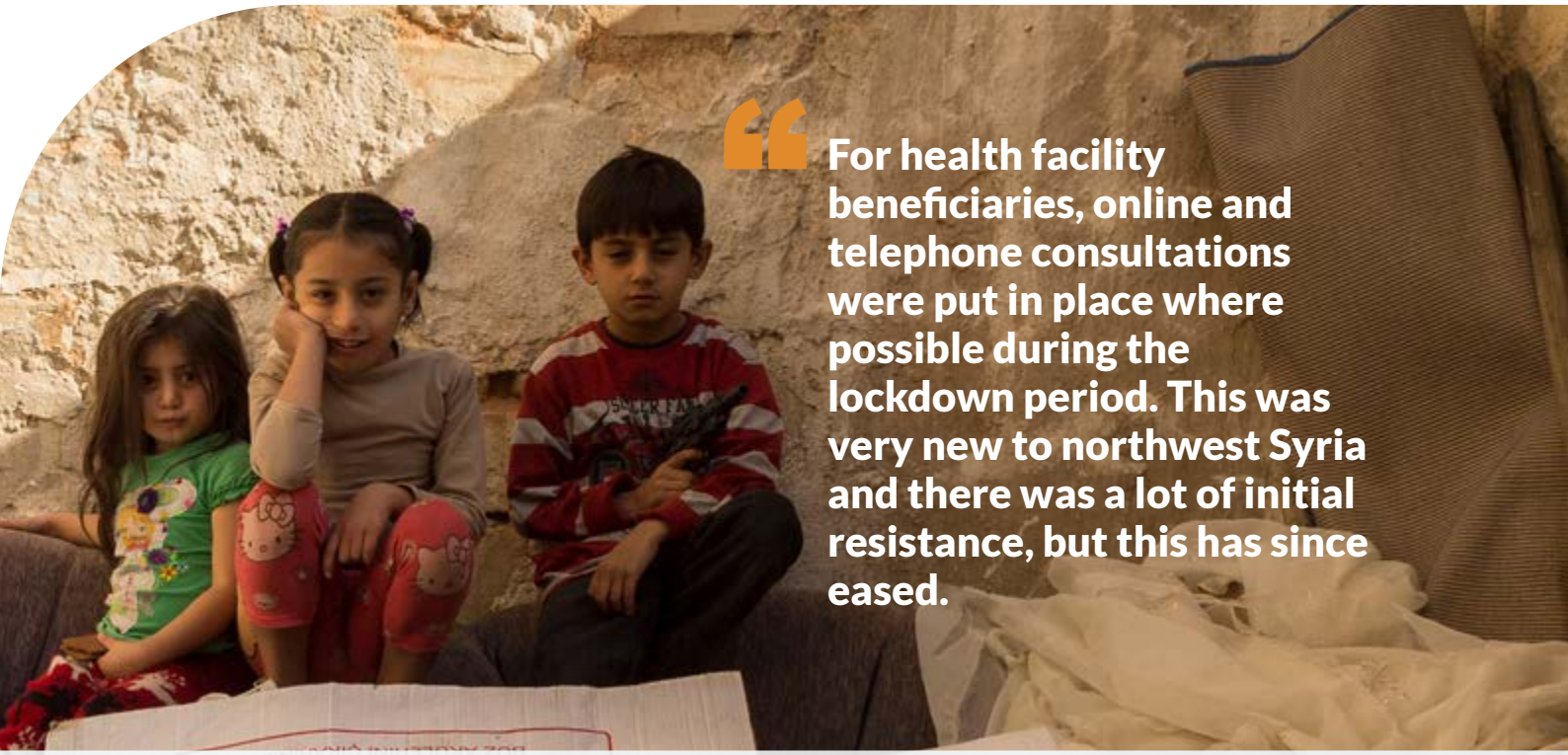
UNFPA Turkey cross border staff report that a particular impact of COVID-19 on their programme was the disruption to the planned focus on older women. It is reported that at the beginning of the pandemic, all partners across the cross-border operation (not just UNFPA partners, but all humanitarian actors) took extreme measures and closed everything but then clusters worked together and provided effective guidance on how to safely continue service provision. Syria itself is now in a containment stage of the pandemic, and for UNFPA and partners this means that everything is operating close to normal, but just with certain IPC measures in place including: social distancing, hand sanitising, and mask wearing.

For health facility beneficiaries, online and telephone consultations were put in place where possible during the lockdown period. This was very new to northwest Syria and there was a lot of initial resistance, but this has since eased.

All FGD participants confirmed that they felt safe and some specifically highlighted the fact that they

121 It was not possible to extract data aligned with the CFF questions around impact of services. From the TPM reports, there is only the qualitative data from the three FGDs conducted for impact questions for Turkey cross-border operations.
122 WGSS FGD participant.
123 Ibid.
124 Ibid.

feel safe because there are no men there, which is important as it reinforces the global standards of keeping WGSS female spaces only. All FGD participants confirmed that they were respected (and "valued") in the WGSS centres.



> **For health facility beneficiaries, online and telephone consultations were put in place where possible during the lockdown period. This was very new to northwest Syria and there was a lot of initial resistance, but this has since eased.**

ACCESS

The UNFPA Turkey cross-border operation conducts regular monitoring of activities through a third party (SREO Consulting[125]) in northwest Syria, and the information below is collated from their TPM reports in addition to interviews and three FGDs. No CFFs were distributed. Therefore it is presented in a different format from other countries.

In general, protection services and safe spaces are scarce across northwest Syria. Different TPM reports consistently highlighted the fact that there was none to limited overlap with other service providers in the community for both health facilities and WGSS. For TPM reports, SREO bases this on beneficiary and staff feedback.

Referrals and updated mapping of services was *"available, organised, and used in all facilities monitored".*[126]

Specific TPM reports consistently highlighted the lack of services available:[127]

85% of households **do not have access to any psychosocial support and/or community space**;

44% reported a **lack of safe spaces for women and girls**;

16% **cannot access healthcare** services when needed.

This is confirmed by both UNFPA staff and partner staff interviews, with many reporting that UNFPA-supported services are the only RH and / or GBV services in any particular location.

125 https://sreoconsulting.com
126 SREO TPM report.
127 across different SREO TPM reports.

It is reported that there is an increasing number of Syrian organisations focused on GBV, but that these have all been supported by UNFPA either directly or through the cluster system. GBV is not an issue that any of the de facto authorities in north-west Syria address, thus without UNFPA there would be next to no GBV prevention or response services. There are no formal legal institutions, so there is essentially no justice for GBV survivors. UNFPA is currently the only agency that provides dignity kits.[128]

Throughout northwest Syria, there are no formal governance structures, only multiple de facto authorities and related institutions. Without international assistance and humanitarian aid, health services would collapse. UNFPA is the only organisation providing RH kits. For a prioritisation exercise of all health facilities, UNFPA used the indicator of 'unique facility' and within this exercise 80% of facilities were deemed essential.[129]

Most of UNFPA partner staff reported that where there are other services available, they are private and not free.

For WGSS, there are no substantial alternatives to the UNFPA model. Most partner staff reported that there are no other nearby centres that provide anywhere near the range of awareness-raising, case management, psychosocial support, and vocational and educational activities for women and girls.

FGD participants unanimously supported this:

> *"No, there are no other centres, and if this centre did not exist, I would feel something is missing, as I need this centre."*[130]

> *"There are no other centres, and I would be locked in the house."*[131]

> *"My husband does not allow me to leave the house except to go to the centre."*[132]

With respect to barriers, TPM reports highlight that overall, women and girls report easy access to facilities. The main challenges are related to transport: either lack of or cost of transport. TPM reports underline the fact that many facilities provide transport for the most vulnerable beneficiaries.

Figure 33. TPM reports: respondents describing accessibility

	Easy	Difficult
Health facilities	93%	7%

For WGSS, participants across all three FGDs unanimously reported that access was easy, with many referencing a car that picks them up.

In terms of awareness about services, health facility beneficiaries primarily learn of services through word of mouth and neighbours, with TPM reports referencing that only 1% hear through referrals, 2% through outreach services, 5% through IEC and 3% through social media.

WGSS FGD participants reported hearing of the centre mainly through friends (adolescent girls); family members and outreach activities (people with disabilities); and neighbours (older women).

With regard to opening hours, health facility staff report that opening times of facilities are based around preferred access times for women and girls, with maternity services being 24 hours.

For WGSS, opening hours are 8am to 4pm which staff report as being convenient and this is confirmed

128 UNFPA has cooperated with World Vision to take over dignity kit distribution if UNSCR is not renewed.
129 UNFPA key informants.
130 WGSS adolescent girl FGD participant.
131 Ibid.
132 WGSS elderly woman FGD participant.

by all FGD participants.

Reaching the most vulnerable

UNFPA GBV staff and WGSS staff confirm that services are directed at the vulnerable, and there has been significant investment in identifying particularly vulnerable groups in cross-border operations, including adolescent girls, widows and divorced women, older people, and women and girls with disabilities. One of the main modalities for reaching and identifying the most vulnerable has been through the WGSS outreach teams. These are mobile teams consisting of protection staff who visit IDP camps and informal shelters in the area, which enables them to reach a high number of women, girls, men and boys.

Through GBV awareness raising at these locations, the outreach teams have been able to reach out to those most in need. There is a focus on the category of widows, particularly within the context of NW Syria as many widows reside in a displacement camp specifically for widows, with restrictions on their movement and often with sons over the age of 14 who cannot stay in the camp, thus making widows a particularly vulnerable group.

Adolescent Girls

A UNFPA survey of RH NGOs operating in north-west Syria from 2019[133] *asked a number of questions with regard to reaching adolescent girls, with the highlights collated below:*

1. 18.75% of organisations have specific and pre-designed adolescent girl programmes;

2. 31.25% of organisations specifically track adolescent girls' access to RH services;

3. 25% of organisations have provided training to staff on working with adolescent girls.

UNFPA has strengthened the "Young Mother Club" initiative that targets adolescent girls who are pregnant or have had their first child, and the "My Safety, My Wellbeing" programme that empowers adolescent girls to prevent child marriage. In addition, UNFPA provides training to a variety of partners on adolescent girl friendly initiatives, including training health care providers on how to work with and engage adolescent girls and trainings on adolescent friendly WGSS.

Disabilities

A 2020 multi-sectoral needs analysis in north-west Syria[134] highlighted that 61% of households have at least one member with one or more disability and/or impairment, including visual impairment (38%), mobility issues (32%), cognitive impairment (15%), hearing problems (15%), communication difficulty (8%) and self-care difficulties (11%). UNFPA Turkey cross-border operations are still working on accessibility and inclusion of vulnerable PWD to the services provided in ALL its supported delivery points, both directly and through the cluster system.

Health facility staff highlight the measures put in place for both older people and those with disabilities, including having transportation available for those with limited mobility (confirmed by WGSS FGD participants).

Partners highlight that UNFPA require tracking against a people with disabilities indicator for services.

One TPM report confirms that: *"Most facilities have some sort of equipment or infrastructural adaptation to ease access for beneficiaries with limited mobility".*[135]

But also suggests that: *"Despite these measures being implemented differently across facilities, it would be important to harmonise the approach to better cater to the needs and priorities of PWD and other vulnerable patients by adding railings and ramps, seated toilets, wheelchairs, crutches, and others. When these adaptations are not possible, facilities should consider conducting more outreach and home visits to*

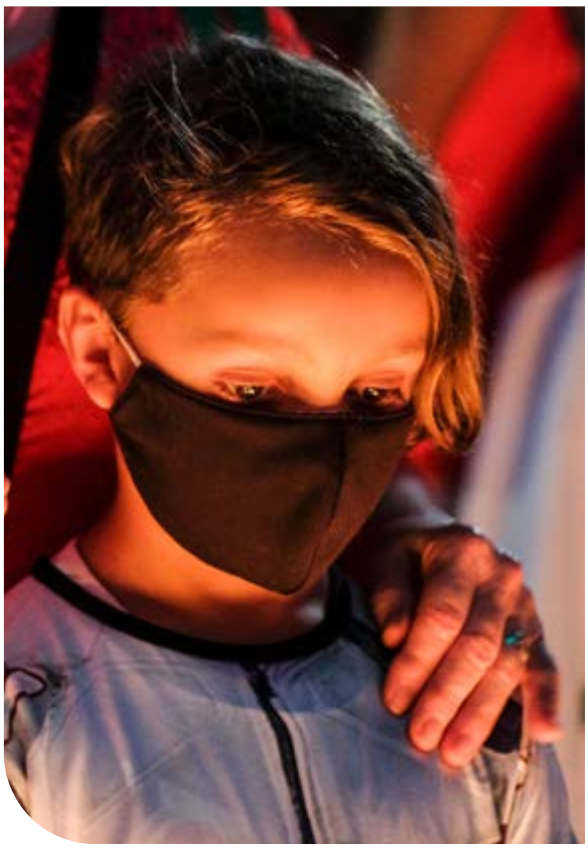
133 UNFPA. [internal PowerPoint presentation] RH Services in Northwest Syria – Survey results April 2019. 2019.
134 DDD HIHFAD. Multi-sectoral needs assessment. Northern Aleppo Governorate. 2020.
135 SREO TPM Report.

bring services to those who cannot easily move to the facility itself for reasons different from transport."[136]

COVID-19 – effects on accessibility, and UNFPA mitigation measures

Health facility staff in NW Syria report that services continued to be provided throughout the pandemic in clinics although with protective measures in place. Many highlighted that due to the low awareness of COVID-19 among the populations, there was a lot of complaints about the measures being put in place.

For WGSS services that were closed at the beginning of the pandemic, these have all resumed albeit with a cap on the number of beneficiaries attending activities in compliance with COVID-19 issued IPC measures. FGD participants reported that some people stopped coming; particularly older people, and adolescent girls reported they had only stopped accessing the services following respective instructions from their parents. Women in the focus group of those living with disabilities reported they stopped coming for fear of infection, because they believe their immune systems to be weakened by their disability.



UNFPA has ensured protective measures – social distancing, wearing of masks, and hand sanitiser for both WGSS and health facilities. UNFPA has provided PPE to all supported health facilities and provided additional funds to the WGSS to put protective measures in place, including masks for staff and outreach teams. Additionally, UNFPA has been advocating for masks and other PPE equipment to be made available for beneficiaries of WGSS and health facilities.

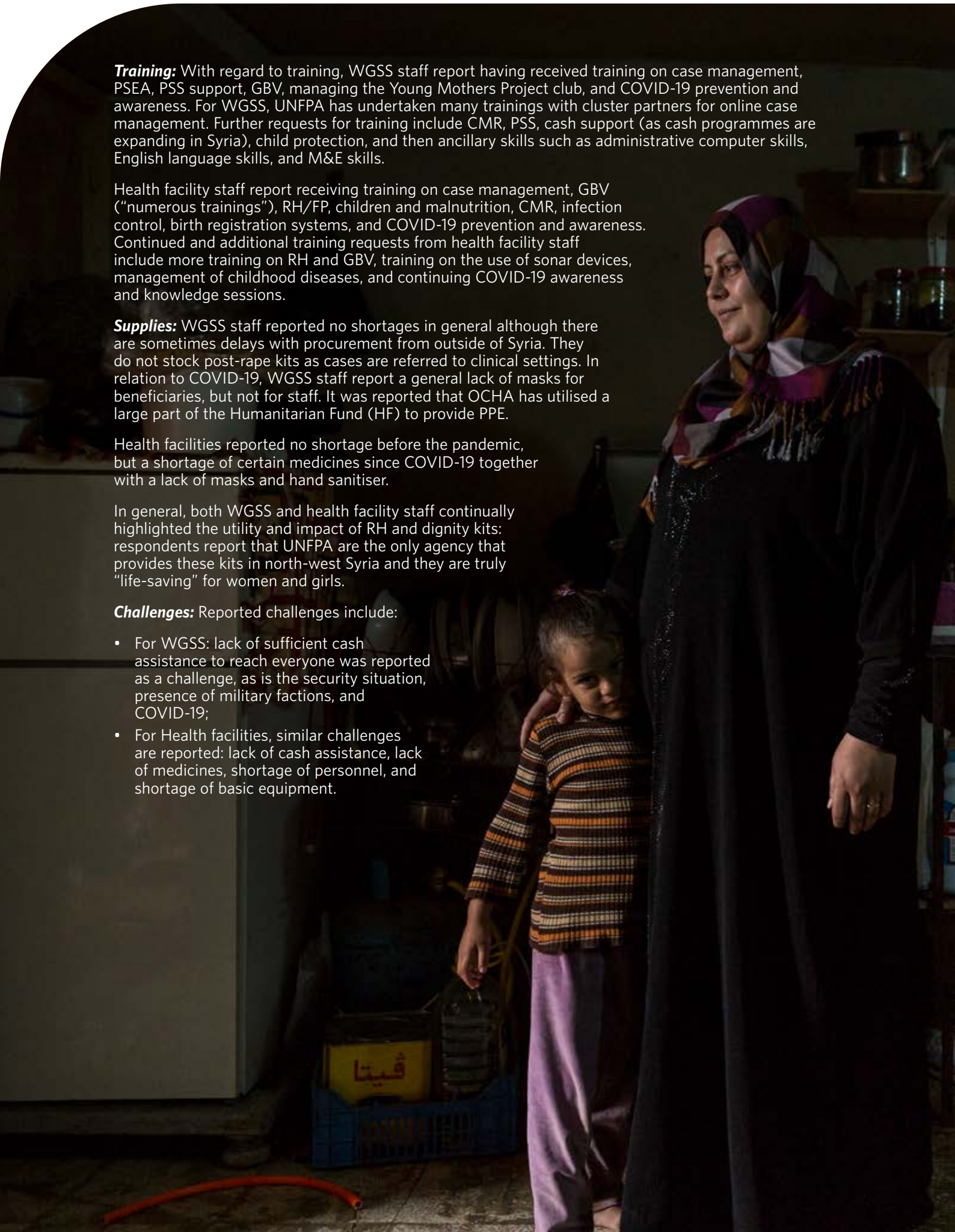
Further measures included reducing numbers in clinics and working on appointment systems only; providing additional community awareness of COVID-19; and providing remote / virtual services.

EFFICIENCY

Staffing: For Turkey cross-border operations, WGSS staff generally report an inadequate level of staff. In relation to COVID-19, some report an increased need for outreach workers while others report no additional requirements.

Health facilities also report a general lack of staff and are united in the clear need for additional staff during the COVID-19 pandemic, particularly with respect to raising awareness, organising remote / virtual services, infection control protocols, and regulating entry to hospitals and clinics.

136 Ibid.



Training: With regard to training, WGSS staff report having received training on case management, PSEA, PSS support, GBV, managing the Young Mothers Project club, and COVID-19 prevention and awareness. For WGSS, UNFPA has undertaken many trainings with cluster partners for online case management. Further requests for training include CMR, PSS, cash support (as cash programmes are expanding in Syria), child protection, and then ancillary skills such as administrative computer skills, English language skills, and M&E skills.

Health facility staff report receiving training on case management, GBV ("numerous trainings"), RH/FP, children and malnutrition, CMR, infection control, birth registration systems, and COVID-19 prevention and awareness. Continued and additional training requests from health facility staff include more training on RH and GBV, training on the use of sonar devices, management of childhood diseases, and continuing COVID-19 awareness and knowledge sessions.

Supplies: WGSS staff reported no shortages in general although there are sometimes delays with procurement from outside of Syria. They do not stock post-rape kits as cases are referred to clinical settings. In relation to COVID-19, WGSS staff report a general lack of masks for beneficiaries, but not for staff. It was reported that OCHA has utilised a large part of the Humanitarian Fund (HF) to provide PPE.

Health facilities reported no shortage before the pandemic, but a shortage of certain medicines since COVID-19 together with a lack of masks and hand sanitiser.

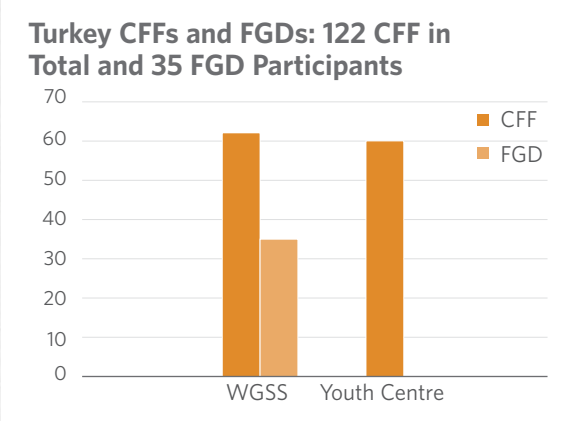
In general, both WGSS and health facility staff continually highlighted the utility and impact of RH and dignity kits: respondents report that UNFPA are the only agency that provides these kits in north-west Syria and they are truly "life-saving" for women and girls.

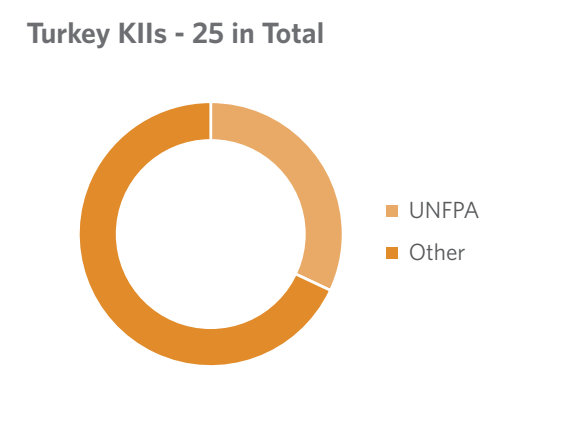
Challenges: Reported challenges include:

- For WGSS: lack of sufficient cash assistance to reach everyone was reported as a challenge, as is the security situation, presence of military factions, and COVID-19;
- For Health facilities, similar challenges are reported: lack of cash assistance, lack of medicines, shortage of personnel, and shortage of basic equipment.

TURKEY

Figure 34. Turkey data sources





IMPACT

UNFPA Turkey provides ongoing support to Syrian refugee women and girls, and youth, through 6 WGSS and 4 youth centres.

In previous years, UNFPA managed over 40 WGSS, all but six of which have now been transferred to the Government of Turkey and integrated into the Government migrant health centres (MHCs). The first WGSS was established in 2015 and became a solid model across Turkey, similar to the model utilised in other countries in the region. Turkey was always a more complicated response than other countries within the Syria regional response group, due to the language issue and the fact that UNFPA Turkey is under a different Regional Office than Syria, Jordan, Iraq, and Lebanon.[137] The language issue proved a huge barrier for Syrian women, girls and youth in state institutions to begin with, which had limited translation capacity, so the UNFPA supported WGSS and youth centres filled a critical gap. UNFPA also used the WGSS model to provide primary health care services directly, with midwives, nurses and even doctors on site able to provide basic RH services. A referral system allowed women and girls to access a breadth of other services. In addition, the WGSS provide counselling, information, distribution of hygiene and dignity kits, and empowerment, vocational and education (mainly language) courses. There are also, in certain centres, access to additional services such as vaccinations and cervical screening.

137 UNFPA Turkey is under the Eastern Europe and Central Asia regional office (EECARO) while all other Syria regional response countries are under the Arab States regional office (ASRO).

Some UNFPA partners report that WGSS are also used to provide GBV awareness sessions to men. While these sessions occur outside of times women visit, and outcomes are reported as positive, as highlighted by the 2018 Syria Regional Response evaluation, WGSS facilities being used for male activities is problematic as it no longer remains a safe space for women and girls and global evidence shows that in these cases the most vulnerable women and girls are forbidden from accessing the space by their husbands and fathers. In most societies, women and girls have limited spaces to meet, with public spaces largely inhabited by men and the purpose of a WGSS, as highlighted by global guidelines – developed by UNFPA – is to provide a space especially for women and adolescent girls.

Since 2016, UNFPA has supported youth centres in Ankara, Diyarbakir, Hatay, and Izmir. Through these youth centres, SRH and GBV services are provided to young refugees through a youth-friendly approach, together with other activities such as capacity building, awareness and empowerment activities, and social cohesion activities for Syrian and Turkish youth together. Health mediators, who access youth through the community, are a strong component of the UNFPA youth programme in Turkey. The youth centres target groups of 15-30/35.[138]

Figure 35. Ranking of importance of receiving services, from client feedback forms in Turkey:

	Absolutely essential	Very important	Of average importance	Of little importance	Of no importance
 **WGSS**	61%	34%	5%	0%	0%
 **Youth Centre**	40%	43%	17%	0%	0%

Male WGSS FGD participants reported the benefit of attending awareness sessions at the WGSS, regarding child marriage and gender discrimination.

Girls highlighted the benefit of having pamphlets and leaflets in Arabic to read, and also reported that the fact that their mothers were treated so well in the WGSS encouraged them to also attend.

Women in FGDs were clear on the benefits to their self-confidence and in turn, how that has transformed their home life:

> *"We have learned about laws and our rights. I was on the verge of divorce with my husband. I could not communicate with him and suffered extreme violence [sad and weeping]. My children would witness violence. I was ashamed. I was living as if all those things that society taught me were my fault. I was dependent on my husband and I could not even move without getting his permission. After participating in these activities, I understood that I am an individual. I learned my rights and realised my power. I stopped my husband when he attempted to hit on me. Now, I do not ask for permission to leave home or do something, but I just go and do it. I feel like the President of Turkey!*

138 One service provider informant reported the age range was 15-35. UNFPA reports that youth centres are designed for those that are 15-30. Global guidelines for working with and for young people in humanitarian contexts (currently in the process of being endorsed by IASC and developed under the Compact for Young People in Humanitarian Action, for which UNFPA is a lead) confirm the globally agreed age ranges of 10-19 being adolescents; 15-24 being youth; and 10-24 encompassing both groups and termed 'young people'. It is important to consider, when opening youth centres to older adults (a) how much this denies services to UNFPA target audience of adolescent girls, particularly when there are 30 year old married men in the centre so many girls will be unable to be within that same space; (b) how this aligns with the UNFPA mandate and target constituency and (c) what is the duplication of services when married adult women are accessing services through a youth centre rather than a WGSS.

> *"Previously, I would do nothing for fear of making an error. Now, I carry on, even if I make mistakes, because I learn from my corrections. I had neither internet nor social media in the past. I did not even have a mobile phone. I did not know what it was. After coming to KAMER and participating in activities, I use all of WhatsApp, Facebook, Twitter, Instagram. I started my jazz after the age of 40. My husband has been affected by my transformation and change. Now he asks my opinion before doing something."*[139]

Women with disabilities in FGDs also highlighted the benefit of attending sessions.

> *"I feel like an important person – like a strong person when I come here. There are a lot of things. When I come here, I say that I exist. I feel my existence and feel stronger when I come here. I am a disabled person but when I come here, they treat me with compassion. I feel that they value me and I don't feel weak."*[140]

> *"I also benefitted a lot from coming here. For instance, as a woman I wasn't able to go outside before. I was like a child. But now I can go out on my own. I live my own life not anyone else's. For example I have a disability but here everyone accepts you as you are. So they don't say, you have a disability, we can't work with you. They accept people here as they are."*[141]

Regarding ideas for improvement, many men and women in the WGSS FGDs requested additional Turkish language lessons, for themselves and for their children. They also requested additional vocational courses and linkages to job opportunities where possible. Turkish language courses were one of the most appreciated activities, across all genders and age groups and in both WGSS and in youth centres.

COVID-19

Youth centre respondents reported that vulnerable and disadvantaged groups were, of course, the most impacted by COVID-19. Also that domestic violence has increased.

However, in general UNFPA and partners were receiving requests for more basic needs – concerns over losing homes through not paying rent (having lost income and employment due to the pandemic), and not having electricity or food. In that respect, there has been a significant increase in requests for cash assistance.

UNFPA reported that throughout the lockdown, there was a continuous demand for WGSS to resume face-to-face services, which highlighted the importance with which women and girls hold access to these services. One unforeseen benefit to changing modalities due to the pandemic was, as reported by UNFPA, a more holistic way of reaching whole families via telephone or online platforms such as Skype: they have reported that awareness-raising sessions conducted online were often attended by the whole family and they felt that in this respect, husbands and fathers were learning something, and it went some way towards behaviour change.

For youth centres, even though the physical centres closed, activities continued online. UNFPA partners report a dramatic increase in unemployment among young people and subsequently increased psychosocial stress, with counsellors reporting more youth speaking about suicide than before.

While there was a decrease in the number of women who accessed WGSS throughout the pandemic, girls reported continuing to come as they felt safe, as long as there were mitigation measures in place (social distancing, wearing masks, hand sanitising) and they did not want to be alone at home.

139 WGSS FGD participant.
140 Ibid.
141 Ibid.

All WGSS and youth centre FGD participants felt both safe and respected in the centres.

> *"The safest place I have ever felt has been the facility."*[142]

ACCESS

UNFPA confirm that there are other services generally available for refugees in Turkey. When the first influx of Syrian refugees came into Turkey, a number of NGOs arose for the response and the whole UN system was mobilised as a partner of the Turkey government. The Government of Turkey received, and continues to receive, significant support from the EU in particular to support Syrian refugees for basic services including health and social support through migrant health centres (MHCs) and social service centres (SSCs). Indeed, 30 of UNFPA WGSS have been transferred into MHC and UNFPA has also supported services through SSCs.

However, WGSS staff highlight that there no other centres that provide the same integrated protection and health services as the WGSS model, which can provide certain aspects of the MHC, the hospital, and the SSC. It also provides counselling and then referrals, so it is reported that many beneficiaries prefer to access the WGSS first before being referred.

> *"It is generally a centre where we can get all services from one place and there is no other place like this centre. If this centre was not available, our lives would not be easy."*[143]

Youth centre staff reported that there aren't so many other services available targeting the youth population, either for Turkish youth or refugee youth.

Figure 36. CFF respondents describing accessibility

	Easy	Moderate	Difficult
WGSS	94%	6%	0%
Youth Centre	70%	25%	5%

Almost all WGSS and youth FGD participants confirmed easy access and no specific challenges were raised by anyone. For WGSS CFFs, a few responses vis à vis access challenges mentioned security issues, no accompanying person, and lack of childcare. For youth centre CFFs, one response referenced sexual harassment on the way to the facility, and some referenced security, transport (cost or and lack of), family restrictions, and distance to location.

In terms of awareness of services, beneficiaries of both WGSS and youth centres receive information about the services in very similar ways: for all beneficiaries, neighbours, family and friends, word of mouth is the most common ways they hear of services.

142 WGSS FGD participant.
143 WGSS FGD participants – summarised by facilitator.

Figure 37. Convenience of opening hours

CFF respondents reporting opening hours are not convenient

WGSS	Youth Centre
3%	0%

All youth centre staff and FGD participants confirmed the convenience of the opening hours, mirroring the CFF responses which was a 100% satisfaction rate.

For WGSS beneficiaries, all FGD participants confirmed the CFF responses (97% satisfaction rate) agreeing that the opening hours are convenient.

Reaching the most vulnerable

In general, the WGSS and youth centres in Turkey do not just provide services to Syrian refugees, but also to refugees of other nationalities who are often considered to be more vulnerable. Furthermore, UNFPA Turkey manage the KRG project which provides services to refugee LGBTI individuals, sex workers, and those living with HIV (PLHIV). This project is specifically and successfully reaching extremely vulnerable refugee populations in a way that other UNFPA COs in the Syria response and more globally struggle to do. In addition, UNFPA Turkey has developed a rural refugee project, in the five provinces with the largest agricultural land and the longest agricultural season, which host significant numbers of refugee migrant seasonal workers. UNFPA has established 12 mobile teams in these five provinces and they work in coordination with provincial health teams with the intention of transferring the project to the Ministry of Health in the same manner that WGSS have been transferred into MHCs.

Adolescent Girls

UNFPA Turkey has had a youth centre model to try and reach both male and female adolescents and youth since 2015. In addition, they have strengthened adolescent girls services in WGSS by providing youth-friendly service training to service providers.

Disabilities

Staff across both types of service units confirm that centres are disability and child friendly. However, some WGSS struggle with accessibility issues. In addition, many refugee women and girls with disabilities do not want to leave the home, citing cultural 'sensitivities'. UNFPA WGSS staff admit that these are issues that have been discussed for years and are still keen to achieve better

services for those with disabilities: now that the majority of WGSS have been transferred to the MHCs, UNFPA is focusing on those most vulnerable – to date key refugee populations and rural refugees, but also wanting to expand work with refugees with disabilities. In the meantime, there is already a level of disability inclusion within WGSS services: *"The service unit ensured children with disabilities participate in child activities and I was affected very much by this"*.[144]

Where WGSS centres are not disability friendly there is still an attempt to reach those with disabilities through health mediators or through their families who come to the centre.

UNFPA Turkey has the added complication of language, with a lot of work being conducted through translators, so training on disability inclusion is not just training for service providers, but training for all translation staff as well.

Youth centre staff report that they are not specifically working with youth with disabilities and that in order to do so, they would need additional funding to adjust all activities. They acknowledge the intersectionality and the fact that youth with disabilities might want to come to our centres, but the physical infrastructure adjustments (for those with mobility disabilities) would cost too much.

COVID-19 – effects on accessibility, and UNFPA mitigation measures

For WGSS, accessibility was impacted by COVID-19 based on:

- those with chronic diseases fearful of coming to the centres;
- those coming by public transport fearful on using the transport;
- some who became infected or had infected family members.

For youth centres, accessibility was impacted by COVID-19 based on:

- ease of accessing activities and services remotely.

Figure 38. CFF respondents who reported stopping access to services due to COVID-19

CFF respondents who stopped accessing services due to COVID-19

WGSS

18%

Youth Centre

95%

UNFPA Turkey and youth centre staff were quick to highlight that in terms of youth centres, they were one of the best groups for easy adaptation to adjust activities to a digital space. The staff themselves are predominantly young people who are already digitally literate, and working with other youth with the same capacities, which all made the adjustment easier. When the pandemic started, youth centres immediately moved to online awareness sessions and activities, with campaigns on Facebook and Arabic and Turkish sessions on Instagram, and even with webinars on YouTube. All staff were provided with phones and sim cards, and contact details for all beneficiaries were updated. However, communication with those youth who did not have access to Internet service, was challenging.

144 WGSS adolescent girls FGD participant.

> **Youth centres report the need for more health centre staff; a role which requires a specific profile in terms of being a qualified medical service provider but also experience working with youth, experience working with vulnerable refugee populations, and Arabic / Kurdish speaking.**

UNFPA Turkey also put in place a number of mitigation measures within WGSS including working online for case management, through WhatsApp and social networking sites, reducing the number of participants in group activities complying with social distancing guidelines and mask wearing etc. WGSS staff are currently researching a system for information activities to be provided through Zoom.

EFFICIENCY

Staffing: In general, Turkey CO and partners report sufficient staff but – unlike all other countries – translation is a big challenge. Many Turkey respondents also report the need to increase *male* staff in both youth centres and WGSS although no further rationale for this request was provided.

Youth centres report the need for more health centre staff; a role which requires a specific profile in terms of being a qualified medical service provider but also experience working with youth, experience working with vulnerable refugee populations, and Arabic / Kurdish speaking. During COVID-19 demand for services and activities online increased and therefore the staffing requirement also increased.

WGSS staff specifically highlight the difficulty with translators and in addition to that, childcare in centres. There was no COVID-19-related need for additional staff.

Training: In general, UNFPA Turkey has ensured COVID-19 ongoing training and support for all partners and service providers, which includes initially weekly and then bi-weekly online meetings with all 10 WGSS and youth centres to provide updates; new information; a platform for exchanging ideas; short capacity building sessions on COVID-19-specific aspects of service provision such as remote case management but also more general aspects such as working with people with disabilities, working with youth, and male engagement. This has been very well received and appreciated by all partners and service providers.

Youth centre staff report receiving training in gender, self-care, and COVID-19 protection and mitigation measures. Youth centre staff would welcome further training in working with people with disabilities, referral pathways (including information on other services available), integration and social cohesion, COVID-19 prevention, protection, mitigation and COVID-19 communication and messaging techniques. In addition, youth centre staff strongly request, in relation to COVID-19, computer training (Microsoft and use of online platforms such as Zoom).

WGSS staff report training received in PSS counselling, working with people with special needs and disabilities, SRHR, refugee employees in rural areas, and COVID-19 protection and mitigation. WGSS staff would like more training in working with people with disabilities, the use of social media for services, working with older beneficiaries, and Arabic lessons. For COVID-19, there are specific requests for additional training / knowledge on the impact of COVID-19 on domestic violence – how to understand, measure, prevent, respond to – and COVID-19 and pregnancy care.

Supplies: In general, Turkey service units – both WGSS and youth centres – have adequate supplies and equipment. Since COVID-19, there has been an increase in demand for hygiene kits – and adapted hygiene kits, with masks and hand sanitiser – which has mostly been met. UNFPA reacted in a context-specific manner to COVID-19 in regard to supplies, dependent on local regulations and restrictions. So, where it was clear lockdown measures would be put in place, UNFPA ensured service providers had the capability to offer remote services with the provision of phones and / or tablets with cameras for all outreach workers, and tripods where necessary, so outreach workers could comfortably run individual and group sessions online, as well as internet cards. During the normalisation and reopening phase UNFPA supported implementing partners to undertake COVID-19 assessments of all physical spaces and provided assistance to enhance those spaces, for example with separators and markings on the floor to ensure social distancing, and also with supplies of masks and hand sanitiser.

Youth centre staff report supplies were adequate, and even during COVID-19 they had enough hygiene kits, and also received masks, gloves, visors, and disinfectant.

In WGSS there was a reported shortage of contraceptive methods (both the pill and the IUD) and problems with the internet and electricity. WGSS report that RH kits are very useful, with the most sought-after items being condoms and pregnancy tests. There are no post-rape kits as women are referred. There was a reported shortage of mobile phones, computers, and internet access during the height of the pandemic, despite the attempts to ensure these things were all in place. There was also a reported shortage of quality masks for staff and beneficiaries.

Challenges: Reported challenges include:

- For WGSS: there is a reported challenge in terms of WGSS sharing the same site as the Migrant Health Centres (MHCs) where sometimes there is conflict between the two services; also the sites are not always disability friendly; COVID-19 produced some challenges in terms of reduced staffing (with staff off sick or isolating); in addition, some staff report challenges with approvals (in Hatay) and others, challenges with beneficiary access to WGSS (in Istanbul);
- For youth centres: COVID-19 was reported as the biggest challenge.

> **WGSS staff would like more training in working with people with disabilities, the use of social media for services, working with older beneficiaries, and Arabic lessons.**

Restoring Balance

2020 IMPACT ASSESSMENT REPORT OF THE UNFPA MULTI-COUNTRY RESPONSE TO THE SYRIA CRISIS: IRAQ, JORDAN, SYRIA, TURKEY AND TURKEY CROSS-BORDER PROGRAMMES

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