



2022 IMPACT ASSESSMENT OF UNFPA's REGIONAL
HUMANITARIAN RESPONSE
IRAQ, JORDAN, LEBANON, SUDAN, SYRIA,
TÜRKIYE, TÜRKIYE CROSS-BORDER and YEMEN
HUMANITARIAN RESPONSE PROGRAMMES

AGAINST ALL ODDS

VOLUME I

ASSESSMENT REPORT

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TABLE OF CONTENTS

Acronyms and Abbreviations	8
Executive Summary	11
Key Findings	12
DIMENSION A: Wellbeing	12
DIMENSION B: Access	13
DIMENSION C: Efficiency	15
CONCLUSIONS	16
Recommendations	17
Section 1. Introduction and Methodology	19
Overview of the impact assessment	19
Background	19
Overview of the UNFPA humanitarian response.	20
Recommendations from the 2021 Impact Assessment	21
Objectives and scope of the 2022 impact assessment	22
Methodological overview of the 2022 impact assessment	23
Data cleaning, coding, and analysis	25
<i>Quantitative data (Client Feedback Forms)</i>	25
<i>Qualitative data (FIs, FGDs)</i>	25
Learning from the 2021 Impact Assessment:	26
Report Structure	27
Data Sources	28
Section 2. Regional Impact Assessment Findings	32
DIMENSION A: Wellbeing	32
GBV Programming	33
a. The range of services/activities provided at UNFPA-supported facilities.	33
b. Any desired changes or additions to services.	36
c. Importance of and reasons for attending services.	38
d. Satisfaction with/impact of dignity kits.	42
e. Feelings of safety and respect in services and providers and feedback mechanisms.	45
f. Contributions of services to the UNFPA mandate area of GBV.	48
Sexual and Reproductive Health & Rights	53
a. The range of services/activities provided at UNFPA-supported facilities.	53
b. Any desired changes or additions to services.	54
c. Importance of and reasons for attending services.	55
d. Feelings of safety and respect in services and providers and feedback mechanisms.	56
e. Contributions of services to the UNFPA mandate area of SRHR.	57

Youth Programming	60
a. The range of services/activities provided at UNFPA-supported facilities.	60
b. Any desired changes or additions to services.	62
c. Importance of and reasons for attending services.	63
d. Feelings of safety and respect in services and providers and feedback mechanisms.	64
e. Contributions of services to the UNFPA mandate areas of youth.	66
DIMENSION B: Access	68
GBV Programming	68
a. Addressing needs in the absence of UNFPA support.	68
b. Accessibility of Facilities & Services: GBV	71
<i>Physical Access</i>	71
<i>Awareness of Services</i>	74
c. Access of vulnerable women, girls and youth.	75
d. Challenges as a result of COVID-19.	77
e. Cash and voucher assistance programming.	79
Sexual and Reproductive Health & Rights	81
a. Addressing needs in the absence of UNFPA support.	81
b. Accessibility of Facilities & Services: SRHR	83
c. Access of vulnerable women, girls and youth.	83
d. Challenges as a result of COVID-19	85
e. Cash and voucher assistance programming.	88
Youth Programming	88
a. Addressing needs in the absence of UNFPA support.	88
b. Accessibility of Facilities & Services: Youth	89
c. Access of vulnerable women, girls and youth.	91
d. Challenges as a result of COVID-19.	92
DIMENSION C: Efficiency	94
a. Human resources adequacy and needs	94
b. Training and capacity (including user perspectives)	96
c. Facility Adequacy and Needs	98
d. UNFPA RH Kits and Commodities	100
e. Ongoing Challenges, Solutions and Support	101
<i>General</i>	101
<i>Women and Girls' Safe Spaces</i>	102
<i>Sexual and Reproductive Health & Rights</i>	102
<i>Youth Programming</i>	102
<i>DIMENSION D: Comparison of key impact assessment datasets between 2022 and 2021</i>	103
<i>Dimension A (Wellbeing): Importance of accessing services</i>	103
<i>Perceptions of SDP Safety</i>	104
<i>Perception of Feeling Respected</i>	104

TABLE OF CONTENTS

<i>Dimension B (Access): The challenges in accessing these services</i>	105
<i>How Service Users Know of the Services</i>	105
<i>Satisfaction with SDP Staff</i>	105
<i>DIMENSION E: Monitoring of recommendations from 2021</i>	106
Section 3. Regional Conclusions and Recommendations	116
OVERALL SUMMARISING CONCLUSION	116
Dimension A: Wellbeing	116
Dimension B: Access	117
Dimension C: Efficiency	118
Recommendations	119

List of Tables

Table 1: People in Need 2021-2022	20
Table 2: UNFPA key results 2021	21
Table 3: Lessons learned from 2021 Impact Assessment and proposed changes for 2022	26
Table 4: Types of Disability Services Reported by UNFPA and Partners by Country	75
Table 5: UNFPA Countries and CVA 2022	79
Table 6: Training Topics Reported by Partners and Service Providers 2021/2022	96
Table 7: Types of Training Requested by Partners in 2023 from UNFPA	97

List of Figures

Figure 1: Data sources and analysis dimensions	24
Figure 2: Data Collection - Participants by Tool 2020-2022	28
Figure 3: Key Informants by Organisation	29
Figure 4: FGD Participants by Location and Gender	29
Figure 5: FGD Participants by Age Range and Location	30
Figure 6: CFF Respondents by Location and Age Group	30
Figure 7: CFF Respondents by Location and Type of Service	30
Figure 8: Humanitarian GBV SDPs 2022	34
Figure 9: Most Favoured GBV SDP Activities by Country	35
Figure 10: Desired Services in GBV SDPs by Country	37
Figure 11: Desired Vocational Training Activities in GBV SDPs by Country	38
Figure 12: Importance of GBV Services by Country	38
Figure 13: Most Important Things Learned at Safe Spaces/Women's Centres by Country	40
Figure 14: Importance of Accessing GBV Services by Country	41
Figure 15: Safe Space Attendees Reporting Receipt of Dignity Kits by Country	42

Figure 16: Satisfaction with Dignity Kits among Recipients of Safe Space Services	43
Figure 17: Feelings of safety, trust etc. in GBV SDPs by Country	45
Figure 18: Perceptions of Life Improvement in GBV SDPs by Country	48
Figure 19: UNFPA-Supported Health Facilities by Country 2022	53
Figure 20: Most Favoured Health Facility Activities by Country	54
Figure 21: Desired Health Facility Activities by Country	55
Figure 22: Importance of Accessing SRH Services by Country	56
Figure 23: Feelings of Safety, Trust etc. in Health Facilities by Country	57
Figure 24: Perceptions of Lives Improved by Health Facilities by Country	58
Figure 25: UNFPA-Supported Youth Facilities/Spaces by Country 2022	60
Figure 26: Most Favoured Youth Centre Activities by Country	61
Figure 27: Desired Vocational Training services/activities in Youth Centres by Country	62
Figure 28: Desired Education services/activities in Youth Centres by Country	62
Figure 29: Importance of Accessing Youth Services by Country	64
Figure 30: Most Important Things Learned at Youth Centres by Country	64
Figure 31: Feelings of Safety, Trust etc in Youth Centres by Country	65
Figure 32: Perceptions of Life Improvements by Youth Centres, by Country	66
Figure 33: Perceptions of Accessibility of GBV services by Country	71
Figure 34: Challenges Experienced by Attendees at Safe Spaces by Country	72
Figure 35: How Respondents found out about Safe Space services by country	74
Figure 36: PWDs reporting access challenges for Safe Spaces/related services by Country	77
Figure 37: Reduction in Safe Space Usage During COVID-19 by Country	77
Figure 38: Use of Online Safe Space Services During COVID-19 by Country	78
Figure 39: Accessibility of SRHR services by Country	83
Figure 40: PWDs reporting access challenges for Health Services by Country	84
Figure 41: Reduction in Health Facility Usage During COVID-19 by Country	86
Figure 42: Use of Online Health Services During COVID-19 by Country	87
Figure 43: Accessibility of Youth Services to Youth 10-19 by Country	90
Figure 44: How Respondents Found out about Youth Services by Country	90
Figure 45: PWDs reporting access challenges for Youth Services by Country	91
Figure 46: Reduction in Youth Centre Usage During COVID-19 by Country	92
Figure 47: Use of Online Youth Services During COVID-19 by Country	92
Figure 48: SDP User Satisfaction with Staff Information/Capacity by Country and SDP	98
Figure 49: Importance of Accessing Services 2021-2022 by SDP	103
Figure 50: Perceptions of Safety in SDPs, 2021-2022 by Country and SDP	104
Figure 51: Perceptions of RESPECT at SDPs, 2021-2022 by Country and SDP	104
Figure 52: Barriers to SDP Access 2021-2022 by SDP	105
Figure 53: How Respondents Heard of Services 2021-2022 by SDP	106
Figure 54: Overall Satisfaction with Staff in SDPs 2021-2022 by Country and SDP	106

Acronyms and Abbreviations

3RP	Regional Refugee and Resilience Plan
ASRO	Arab States Regional Office
BEmOC	Basic emergency obstetric care
BEmONC	Basic emergency obstetric and new-born care
CEmOC	Comprehensive Emergency Obstetric Care
CEmONC	Comprehensive emergency obstetric and new-born 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
EmONC	Emergency obstetric and new-born care
ESSN	Emergency Social Safety Net
FCDO	Foreign, Commonwealth and Development Office
FGD	Focus group discussion
GAC	Global Affairs Canada
GBV	Gender-based violence
GBVIMS	Gender-based violence Information Management System
HRP	Humanitarian Response Plan
IAED	Impact assessment evidence database
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
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex
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's and Girls' Safe Space
WoS	Whole of Syria



Executive Summary

Executive Summary

This assessment report is the sixth regional external assessment of UNFPA humanitarian programming in the Syrian and Arab States region (incorporating responses to the Syria crisis within Türkiye and cross-border from Türkiye to Syria and UNFPA humanitarian responses in Sudan and Yemen) to report on the impact on women, girls, boys, and men that UNFPA programming has had, across sexual and reproductive health (SRH), gender-based violence (GBV) and youth programmes.

This 2022 assessment builds upon the previous annual impact assessments from 2016 onwards, tracking the evolution of programming through the evolution of the Syrian crisis, the COVID-19 pandemic, and for 2022, incorporation of UNFPA humanitarian response work in the countries of **Sudan** and **Yemen**.

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 or amending existing programmes. This report also informs the donor community to gain a better understanding of UNFPA's operations in both the Syria regional response and the wider Arab States region.

The 2022 Impact Assessment builds on the established methodology of the 2021 Impact Assessment which rationalised and systematised the different tools and questions previously used to conduct research among three types of service delivery points (SDPs) with three primary research tools: Client Feedback Forms (CFFs) among attendees at services, Focus Group Discussions (FGDs) among attendees at services and Key Informant Interviews (KII) with institutional stakeholders – partners, service providers, UNFPA staff. The table below summarises the number of each type of research tool applied.



		Client Feedback Forms	Key Informant Interviews	Focus Group Discussions
	Women's and girls' safe spaces/Women's Centres	3,048	14	117
	Health Facilities	4,380	27	-
	Youth Centres	1,866	6	18
	UNFPA Country Offices	-	18	-

Key Findings

DIMENSION A: Wellbeing

This dimension of the humanitarian response work that is being undertaken by UNFPA looks at the physical and psychosocial wellbeing of those at risk of GBV and GBV survivors and those in need of SRH or youth services.

GBV Services: UNFPA supports several hundred GBV SDPs via its humanitarian programming across the participating countries that provide a range of empowerment, support, case management, training and social activities to thousands of women and girls. While the number of actively-supported SDPs varies over the course of time due to handovers to partners or government; as of mid 2022 a total of 225 women's and girls' safe spaces (Safe Spaces) or women's centres were being supported across the eight humanitarian operations, with increases seen in **Lebanon, Syria, Türkiye and Türkiye cross-border**, though a decrease in **Jordan**.

The most popular activities undertaken in GBV SDPs vary considerably across countries, but in general, vocational training and psychosocial support were the highest-rated services by women and girls, followed by awareness-raising on key topics related to rights and gender.

Safe Spaces/women's centres were universally highlighted by women and girls to be of vital importance to their wellbeing and mental health, facilitated by psychosocial support and stress relief. This was supported by complementary activities such as training/learning new things and socialising with friends or other social or recreational activities. Notwithstanding the high priority placed on various vocational and social activities, the importance of being able to access GBV services was underscored by the vast majority of women participating in the assessments. A key feature of Safe Spaces and women's centres supported by UNFPA is that they are for women and girls only, providing an additional layer of confidence and sense of safety.

In many operations, UNFPA uses Safe Spaces/women's centres as distribution points for **dignity or hygiene kits** in most operations. This is a useful approach to both ensuring that women and girls obtain these increasingly essential and expensive items, and to link the distributions to provision of services, e.g. awareness sessions.

Sexual and Reproductive Health Services: As of mid-2022, UNFPA was directly supporting 296 health facilities across the eight humanitarian responses covered by this assessment. These facilities include fixed health facilities (health posts, health centres, hospitals) and mobile clinics. In many countries, UNFPA continues to be the only provider of SRH care for many women – either within or outside camp settings. The services supported cover family planning, pre-pregnancy care, prenatal care, pre-marriage counselling, PNC, post-abortion care and include home visits for beneficiaries who can't visit health centres.

Women attending health facilities almost universally considered the SRH services offered by them to be either absolutely essential (61% of respondents) or very important (32%).

It is clear from responses by the more than 4,000 women surveyed regarding the health facilities supported by UNFPA that the services delivered there contribute positively to health outcomes in women's lives. Across all countries, 98-100% of women agreed that the facility at which they were attending had made their lives better – a unanimous endorsement. IPs also noted how the quantity and quality of SRH and rights (SRHR) services offered by health facilities are directly impacted by the support of UNFPA, despite the legacy of the COVID-19 pandemic on maternal and neonatal health.

However, despite these reports of success, partners also stressed that the number of health facilities currently supported by UNFPA are inadequate to cover the needs of the populations, particularly in countries hardest hit by conflict (**Syria, Sudan, Yemen**) or by economic crisis (**Lebanon**). While anecdotal evidence indicates positive impact on cases of maternal illness, i.e. mortality averted, these represent a “drop in the ocean” and are against a backdrop of overall poor health outcomes for women and girls. In many cases, UNFPA support is making things “less worse”.

Youth Programming: As of mid-2022, UNFPA was directly supporting 28 youth centres across the eight humanitarian responses covered by this assessment. The centres are located in both camp and non-camp settings. In addition to the support directly to facilities, UNFPA also supports standalone programmes for youth and work via educational institutions and health facilities to reach youth.

The most favoured and relevant services in youth centres reported by youth directly were those related to social, cultural and recreational activities. These were followed by vocational training, education and life skills – key building blocks to future survival by many young people.

As with GBV and SRHR services, the perceptions of the substantial majority (over 95%) of young people attending youth centres in the four supported countries is that they are making their lives better. UNFPA partners report positive effects of awareness-raising and training, especially among young men. They note many are now refusing the idea of early marriage, increased reporting of incidents related to GBV, including a relatively new phenomenon of online abuse.

DIMENSION B: Access

This dimension of the humanitarian response work that is being undertaken by UNFPA looks at the availability of and access to GBV, SRHR, and youth services to refugees, internally-displaced persons (IDPs) and host communities.

GBV Services: For most locations in most country operations, UNFPA is widely-recognised as the only significant player providing GBV support, particularly in camp settings. Some other providers do exist in the GBV sector, primarily NGOs, but many offer a different package of services, and different approaches (e.g., centres open to men, which is a major obstacle for more vulnerable groups).

The accessibility of UNFPA-supported GBV services is a crucial determinant in the quantity and quality of engagement of all who require these services, particularly vulnerable groups such as people with disabilities (PWD) or marginalised groups such as the LGBTQI community. Most respondents (75-85%) to the assessment found accessibility of GBV services to be easy or moderate. Nonetheless, all response locations saw a deterioration in perceptions between 2021 and 2022, with the cost of transportation beginning to affect people more and more as the global economic crisis of 2022 began to bite.

An important area of work that grew in 2021/2022 for UNFPA is the use of cash and voucher assistance (CVA). In 2021, this assessment reported four humanitarian response countries engaging in some form of CVA programme (**Lebanon, Jordan, Syria and Türkiye cross-border**). In 2022, all countries except Iraq were engaging in this modality. For GBV, cash is provided for a range of purposes, either emergency assistance to help women survivors of violence escape their perpetrators, to facilitate attendance at GBV services, or provide direct support to survivors. A number of pieces of research at country level that are being published in late 2022 will help build the evidence-base for cash and the most effective approaches in its usage. Almost all country programmes see scope for expansion of cash programming in some form for the future.

SRH Services: In countries with better-functioning health infrastructure, state (and some non-state) actors are in a position to provide at least some services related to SRHR, whereas in others, NGOs – both national and international – continue to provide another layer of healthcare.



However, despite the presence of other actors, UNFPA in 2022 continues to support either a higher quality of service, or specific SRHR services that are not available elsewhere (e.g. clinical management of rape (CMR) or fistula surgery) or are free of charge. In some countries with camp-based populations, access to outside health facilities is not feasible, increasingly so as the cost of transportation continues to rise and funding reductions constrain service provision, so without UNFPA-supported SRHR services and clinics, women would not have any access to SRH services.

Users of SRH facilities found them to be similarly accessible as GBV facilities, with most respondents (80-90%) considering them “easy” or “moderate” in terms of accessibility. Specific challenges faced by attendees at supported health facilities were focused primarily around transportation issues, as with GBV – with distance of the facility, the cost of transport or the availability of transportation the three main challenges noted by respondents in all country operations, despite efforts by UNFPA and partners to mitigate this issue.

Throughout the region, UNFPA continued to undertake targeted efforts to ensure that all groups facing intersecting forms of discrimination, such as PWDs and older women, have effective access to supported SRH services, either through physical accessibility measures (for instance by building wheelchair ramps, installing handrails, and modifying accessible toilets), or on policy work to facilitate the access of younger people to SRH services in conservative environments, or advocating the elimination of discriminatory practices. In particular, accessibility of SRH services to key populations such as LGBTQI groups is showing increasing progress across UNFPA country operations in 2022.

It is clear that delivery of SRHR services was greatly impacted by the **COVID-19** crisis. Overall, a high proportion (59% on average) of people reduced their usage of health facilities over the past two years. Late 2021 and 2022 saw a gradual reduction or lifting of restrictions on movement and access, and a general return to pre-COVID-19 ways of service delivery, albeit with limited precautions still in place, and preparations made for any needed ramping up of measures. Health actors, however, are more cognisant of the risks of successive waves of infection, so many health service providers are maintaining a state of readiness to act quickly to safeguard their staff and services in this eventuality.

Youth Programming: In the countries where UNFPA supports youth centres, partners note some other facilities that could provide services to youth in the absence of UNFPA. In some cases these are somewhat similar to UNFPA-supported services, but others differ in fundamental ways. The diversity of activities and the positive support and atmosphere were highlighted by young people as being a unique and very strong feature of the UNFPA-supported youth facilities.

Young people participating in discussions highlighted the work that is supported by UNFPA – most of them say there are no other centres that provide youth services for them. Many young people noted that other facilities or clubs are not free of charge, and hence unaffordable.

There are a mix of perceptions between users regarding the accessibility of youth facilities and services. Logistical considerations are the most significant challenge faced by young people – for some, the centres are located close to their residences (especially within camp settings), and walking is feasible and sometimes desired. For others, the distance is too far to walk, and public transportation is either expensive, or perceived to be unsafe (especially for young women).

UNFPA-supported youth facilities report strong efforts to reach as many as they can. As with other facilities, accessibility measures for physical disabilities are the easiest, as (noted by one respondent) “young people will make every effort” to access social/recreational and learning services when there are few other options. Stakeholders note greater challenges in creating accessibility for youth with visual/mental disabilities, but some achievements have been made in 2021/2022, such as developing curricula in Braille. Many youth with disabilities were also supported under livelihood and community participation elements in 2022, and this work continues into 2023.

DIMENSION C: Efficiency

Human resources for supported services over 2021 and 2022 has been variable across different response countries. For some Safe Spaces, there are adequate case workers, outreach workers and volunteers to ensure smooth running of the facilities. For other partners and service providers, human resources is a challenge.

For health facilities, as skillsets become more specialised, staff become harder to recruit and retain. The lack of specialist medical staff has been noted by many implementing partners (IPs) and facility stakeholders, as well as being well-recognised by community members seeking care. A further challenge is the high level of turnover of qualified and experienced staff, often from national NGOs to higher-paying and higher-status international organisations or donor-funded projects/ programmes. This was exacerbated by the COVID-19 pandemic, which disrupted normal patterns of work and led many people to change their work permanently. There are particular challenges in retaining staff at field level where many of the services are delivered and where the greatest value of services is generated. More recently, funding cuts in humanitarian programming which, in 2022, led many SDPs to the verge of closure. This has increased the caseload of UNFPA-supported facilities exacerbating shortages of staff and overcrowded spaces.

Many **facilities** across the response operations report having good (or adequate) facilities and equipment. Many also note that they could always do with additional support, but are doing the best they can with what they have. Others, if they have adequate supplies, express that they feel “lucky”, and thus it is clear that expectations are that shortages are the norm.

In some countries maintenance of equipment is proving challenging due to a shortage of funding. Some health facilities report that technical equipment (e.g. incubators), are old and in line for replacement. UNFPA continues to work to provide required equipment in line with available funding, but not all needs can be met.

As part of work towards its mandate areas, UNFPA provides a wide range of **training** across GBV, health and youth programming for partner staff both in technical and peripheral administrative and IP programme management areas such as budgeting, proposal writing, and monitoring and evaluation (M&E).

In GBV and SRHR programming, UNFPA has continued its support in 2021/2022 in development of technical expertise and supporting capacity building of partners both at field level or within the SDPs and on various topics. Partners attested to how UNFPA provides a variety of training to fit different levels of knowledge and expertise. All partners and service providers underscored in interviews and discussions the importance of training for both ongoing professional development but also to deal with the above mentioned issues of staff turnover.



MANY FACILITIES
ACROSS THE RESPONSE
OPERATIONS REPORT
HAVING GOOD (OR
ADEQUATE) FACILITIES
AND EQUIPMENT.



Partners across most country responses increasingly report need for training on use of various digital tools for data collection and management which take time and effort to learn, but note that the quality of data is very good when complete and can work well to show donors a clear picture of progress and programming.

As with many community members making use of SDPs, several partners noted the utility of conducting so much of the training remotely when COVID restrictions were in place, but that as restrictions (and concerns) abate, there is a clear and widespread preference to return to more in-person training and interactions.

UNFPA has continued to provide **dignity/hygiene kits** and **reproductive health (RH)** kits as part of its programming to most countries. UNFPA COs, IPs and service providers all confirm the vital role that RH kits, mother and baby kits and hygiene/dignity kits play in providing essential and lifesaving medical services at one extreme, and supporting a dignified life at the other.

In some of the UNFPA countries of operation, deteriorating funding environments for refugees and IDPs mean that medical facilities cannot access essential medicines, and deteriorating economic conditions mean that women cannot afford hygiene/sanitation items. Challenges in procurement were reported in 2021/2022 by some countries. A continuum of declining donor interest pre-2022 has been exacerbated by a diversion of attention to Ukraine in 2022.

CONCLUSIONS


The outcomes of a range of different crises around the world have thrown into sharp relief the value of the work that UNFPA has supported across its mandate areas in the past year.

- Firstly, the diminished, but ongoing, impact of the upheavals caused by COVID-19 have highlighted the huge value that UNFPA brings to the health and wellbeing of women, girls and young people across the countries where it works. The often challenging-to-measure benefits of Safe Spaces and youth centres on mental health and psychosocial wellbeing have been underscored by the many people that report having struggled through lockdowns and service restrictions. The reopening of services has been widely welcomed, and despite a legacy of negative outcomes on SRH and wellbeing resulting from the pandemic, there is good consensus that where UNFPA support has been in place, positive progress has been sustained.
- Secondly, the slow but progressively more challenging macroeconomic crisis that has been experienced by most countries is eroding the resilience of rights-holders. Broad-based increases in the cost of living for all mean that the no-or-low-cost SRHR, GBV and youth services and commodities provided by UNFPA are increasingly in demand, as well as increasing the need for ways to improve the accessibility of services. In tandem is the increasing popularity of services that help women and girls to find ways to generate their own income to mitigate increasing economic hardship, but also a sign of increasing empowerment and changing gender norms.
- Thirdly, increasing economic headwinds and the conflict in Ukraine are constraining availability of humanitarian funding and resources that UNFPA and its constituents rely upon. Actors are tasked more and more to make difficult choices on what programming to prioritise and to increasingly do more with less. This has spurred innovative approaches to outreach and training (e.g. linking vocational training or education in centres to formal certification), and a drive to sustainability via a transition of humanitarian programming to longer-term peacebuilding and development modalities, as well as examples of programming handover to national actors.



Recommendations

1. **GBV/Youth:** Review Accountability to Affected Populations (AAP) **plans and feedback/response mechanisms** within SDPs, particularly Safe Spaces and youth centres with a view to:
 - a. Ensuring activities offered at the SDPs are in line with peoples' abilities/capacities, including age-and-ability/disability-appropriateness.
 - b. Ensuring vocational training activities are suited to the economic environment and the wants/needs of the participants to create/support livelihoods opportunities where possible.
 - c. Emphasising existing feedback processes so participants understand that their voices are being heard and acted upon to the extent possible.
 - d. Linking to CVA assistance (in line with the emerging body of practice and expertise within UNFPA) that can complement other programming modalities as an entry point as well as standalone assistance.
2. **Youth programming:** UNFPA should deepen its engagement on youth to fulfil its commitments under the *UN Security Council Resolution (UNSCR) 2250* youth, peace and security agenda and mitigate GBV and negative SRHR outcomes.
3. **Redouble focus on access of vulnerable groups** to all services – not just people with physical disabilities, but those with less visible disability, and groups that may not be able to access services for other reasons – gatekeeping (adolescent girls), prejudice (LGBTQI).
4. **SRHR:** Manage increasingly scarce funding to build capacity of facilities to attract and retain specialist medical staff by recognising and addressing the challenges that drive staff attrition.
5. **COVID-19:** Situations are reverting to business-as-usual across most countries, but pandemic risk is still an issue. Ensure appropriate in-country preparations and resilience (as well as combatting complacency and vaccine hesitancy).
6. Identify and sustain the good practices developed as a result of COVID-19 mitigation strategies, particularly around **telehealth/online GBV/youth services**.
7. To ensure continuity of programming and build programmatic resilience, strategise on mitigation strategies for procurement, distribution and management of commodities (both dignity/hygiene kits and RH kits).
8. **Acute & long-term crises:** Economic hardship and climate change are hitting all countries. Maintain and redouble focus more on practical/efficient solutions – livelihoods linkages, transportation, mobile teams, cash transfers, personal resilience – that go beyond the immediate crises but mitigate future challenges.
9. Leverage the findings and recommendations of the Johns Hopkins University study on the use of **CVA** in Jordan by developing a strategy for scaling-up and expanding CVA programming across all countries.
10. Following on from the yet-to-be actioned 2021 recommendation, conduct research to understand the barriers to **postnatal care (PNC)** in order to develop a regional campaign, particularly linking PNC as an entry point to family planning, as well as investigating the creation of incentives.



Section 1.

Introduction and Methodology

Section 1: Introduction and Methodology

Overview of the impact assessment

This assessment report is the sixth regional external assessment of UNFPA humanitarian programming in the Syrian and Arab States region (incorporating responses to the Syria crisis within Türkiye and cross-border from Türkiye to Syria and UNFPA humanitarian responses in Sudan and Yemen) to report on the impact on women, girls, boys, and men that UNFPA programming has had, across (i) SRH (ii) GBV and (iii) youth programmes.

This 2022 assessment builds upon the previous annual impact assessments from 2016 onwards, including the changes integrated into the 2020 and 2021 assessments:

1. An overall coherent programme impact assessment, inclusive of country-specific chapters, that resulted in one assessment report, shared with all donors.
2. Ongoing responses to the COVID-19 pandemic.
3. The use of cash mechanisms was included within the 2020 assessment.

Importantly, the geographical scope of this assessment has been expanded in 2022 to incorporate UNFPA humanitarian response work in the countries of **Sudan** and **Yemen**. This represents a departure from previous years, which focused specifically on responses to the regional Syria crisis, and reflects the expanded reach of the work undertaken by the UNFPA Humanitarian Response Hub in Amman to these countries.

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 or amending existing programmes. This report also informs the donor community to gain a better understanding of UNFPA's operations in both the Syria regional response and the wider Arab States region.

Background

The year 2022 saw a continuation of the range of humanitarian crises that, in Syria (and surrounding countries) and Yemen, are now within their second decade, and in the case of Sudan, a prolonged crisis dating back decades, the 2011 division of the country into the (northern) Republic of the Sudan and South Sudan and the War in Darfur. In Sudan, the crisis was exacerbated by an October 2021 military takeover of the Sudanese Government, which resulted in the removal of the civilian components of the transitional government, which had come into power in July 2019 and aimed to transition Sudan into a democracy by 2023.

These ongoing humanitarian crises have been heightened in the past year by a worsening and emerging economic crisis resulting from the COVID-19 pandemic, and more recently the global disruptions caused by the conflict in Ukraine and exacerbated by the COVID-19 pandemic. All three conflicts covered by this assessment have led to protracted internal displacement and are yet to find durable solutions with increased insecurity and localised violence in parts of each country. These have been exacerbated locally by a variety of natural disasters within most of the countries covered – floods, disease outbreaks and drought – themselves symptoms of the predicted greater impact of climate change on the eastern Mediterranean/Middle East region.¹

¹ Zittis et al. (2022). Climate change and weather extremes in the Eastern Mediterranean and Middle East. *Reviews of Geophysics*, 60, e2021RG000762. <https://doi.org/10.1029/2021RG000762>



Year-on-year, more people are being affected as a result of the prolonged exposure to hardship and risks. Their worsening situation reflects the deepening and intersecting crises they face. Across the three conflict areas covered by the 2022 assessment, approximately 59 million people are in need in 2022², an increase of 10% on the previous year.

Table 1: People in Need 2021-2022

	2021	2022
Sudan	13.4M	14.3M
Syria	13.4M	14.6M
Yemen	20.7M	23.4M
Iraq	0.24M	0.25M
Lebanon	1.5M	1.5M
Jordan	0.66M	0.7M
Türkiye	3.6M	4.1M
Total	53.5M	58.85M

Overview of the UNFPA humanitarian response.

UNFPA humanitarian responses across the countries in the Syria region are coordinated through the Syria Response Hub in Amman ('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 Arab States Regional Office (ASRO) structure, and before USCR 2165 or the overall Whole of Syria (WoS) Response structure.³ It was established in response to UNFPA recognising the need to scale up the Syria response and improve coordination on a neutral basis between different COs. A Regional Humanitarian Coordinator was appointed in February 2013 with further dedicated posts being subsequently created, particularly in the areas of GBV,

² Humanitarian Needs Assessments 2022 for Syria, Sudan, Yemen


³ In 2014, the 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 extension of the Turkey cross-border (TXB) operation was authorised by the Security Council in July 2022 under UNSCR 2642

communications, and monitoring and evaluation.⁴ The Hub's terms of reference (TOR) were updated in 2020, noting an increased focus on knowledge management and with the creation of additional posts for grant management and humanitarian programmes data.

Key achievements across the response countries for 2021 are highlighted in the table below.

Table 2: UNFPA key results 2021

People Reached and SDPs Supported



	People Reached with GBV services	People reached with SRHR services	People reached with youth services	Mobile clinics	Safe Spaces	Adolescent & youth friendly spaces	Functional health facilities
Iraq	2,148	6,652	2,116	3	72	10	41
Lebanon	9,999	30,022	1,945	0	19	01	16
Jordan	60,399	112,538	10,925	4	11	10	9
Sudan	270,000	380,000	600	0	18	2	44
Syria	211,908	803,509	49,834	56	35	11	85
Türkiye ⁵	46,778	69,579	N/A	69 facilities that offer integrated services via MHCs			
Türkiye XB	298,734	163,147	N/A	0	14	0	6
Yemen	803,869	1,584,175	N/A	4	50	0	93

Recommendations from the 2021 Impact Assessment

1. Roll out knowledge series on transcending gender norms and increase cross-country learning on gender transformative approaches, regularly providing examples from different countries.
2. The Hub to develop a short (2-page) briefing note on the value of Safe Spaces, for country offices (COs) to use for fundraising purposes.
3. COs should consider **reviewing their AAP plans** and build capacity of service providers on provision of information to all beneficiaries with regard to confidentiality protocols, and an **AAP** plan focusing on feedback loops.
4. **For SRH in particular:** Consider conducting research to understand the barriers to PNC to develop a regional campaign, particularly linking PNC as an entry point to family planning and investigating creating incentives.
5. In line with the upcoming SRH/GBV toolkit - Consider strengthening **referrals from health / SRH services** to other services like Safe Spaces.
6. **For youth in particular:** note that in 2022 there will be a global thematic evaluation of UNFPA support to adolescents and youth, featuring both Jordan and Türkiye as case studies. The Hub or the regional office should use this evaluation as a basis to **develop a regional plan particularly with respect to the out-of-centre added value of UNFPA for youth** with regard to both the new Inter-Agency Standing Committee (IASC) guidelines for working with and for Young People in Humanitarian Settings⁶, and the Youth, Peace and Security agenda.

⁴ Audit of Syria Response Syria Response Hub, Jordan April 2017

⁵ It is noted that for the Türkiye country programme, Safe Spaces are integrated into the Migrant Health Centres supported by the MOH and provide both SRHR services at primary health care level and GBV services. In this context, Safe Spaces in Türkiye conducted CFFs with beneficiaries receiving health or protection services and the results were reported separately under GBV and SRHR programming. The youth interventions provided through youth centres were not assessed in Türkiye.

⁶ <https://reliefweb.int/report/world/iasc-guidelines-working-and-young-people-humanitarian-and-protracted-crises-16-february>

7. Following on from the 2020 recommendation: **ensure that outreach and awareness-raising of services (marketing) is distinct from awareness-raising programming** i.e. awareness-raising of rights and gender issues. Secondly, there is a clear opportunity to make much more use of digital outreach and social media.
8. For working with **adolescent girls**, and ensuring accessibility for **PWD**, UNFPA should continue to **keep this focus and work on the trajectory of continued improvement** in these areas across all countries; perhaps ensuring (through this assessment) and ongoing annual stock-take of what improvements in these areas of inclusion have been achieved in the previous year.
9. The Hub should consider developing a guide for how to **increase access to LGBTIQ populations** based on the efforts from Jordan and Lebanon, slowly and carefully.
10. UNFPA should regionally consider developing guidance on how to view **transportation barriers** as they relate to accessing services. UNFPA may want to consider transport as an issue under UNFPA control (while recognising it as an external issues) and use current innovations across the region to provide practical examples and support – demonstrating the use of CVA and also organising transportation directly, so countries can then decide best what works in their contexts.

Objectives and scope of the 2022 impact assessment

The objectives for the 2022 Impact Assessment remain the same as the 2021 assessment. The overall aim of the 2022 Impact Assessment is to examine if the services provided at UNFPA-supported SDPs, including health facilities, Safe Spaces and youth centres, and outreach activities conducted from these static SDPs, are achieving the intended objectives.

The 2022 Impact Assessment targets the following audiences:

Primary audiences:

1. UNFPA ASRO Syria Response Hub, UNFPA COs in Iraq, Jordan, Lebanon, Sudan, Syria, Türkiye cross-border sub-office in Gaziantep, Türkiye and Yemen;
2. UNFPA donors.

Potential secondary audiences:

1. UNFPA ASRO;
2. UNFPA IPs;
3. Other humanitarian and development actors across Iraq, Lebanon, Jordan, Sudan, Syria, Türkiye cross-border operation, Türkiye and Yemen [particularly those working on SRH, GBV, and youth programming];
4. Other UNFPA regional and COs;
5. UNFPA Humanitarian Office.

The 2022 Impact Assessment aims to:

1. Determine the extent of improved physical and psychosocial wellbeing of those accessing SRH services and participating in GBV (prevention and response) and youth engagement programmes;
2. Understand accessibility to and availability of [integrated] GBV and SRH services for those reached by UNFPA programmes;



3. Improve programming where possible;
4. Provide donors with an overview of the impact UNFPA has on the wellbeing of the people reached by UNFPA programmes (e.g. FCDO, Global Affairs Canada, SIDA, ECHO, Finland, Denmark, Italy, Norway, USAID and PRM).

The 2022 Impact Assessment includes data collected during the second and third quarter of 2022 and covers programming that has taken place mid-late 2021 until mid-late 2022.⁷ The following countries/operations have been included: Iraq, Jordan, Lebanon, Sudan, Syria (including Türkiye cross-border operation), Türkiye and Yemen.

Methodological overview of the 2022 impact assessment

The 2022 Impact Assessment builds on the established methodology of the previous Impact Assessment which rationalised and systematised the different tools and questions previously used (2016-2021) into one overarching **Impact Assessment Framework (IAF)**.

This overarching framework looks at three types of SDPs, including associated outreach activities where applicable. These are:

- a. Safe Spaces;
- b. Health Facilities;
- c. Youth Centres.

There is then an overarching framing of three dimensions:

- a. A. Wellbeing;
- b. B. Access;
- c. C. Efficiency.

The final two sections of the report provide a comparison of results and activities between 2020 to 2021:

- a. D. Comparison to 2021 across Dimensions A, B, and C.
- b. E. Monitoring of Recommendations from 2021.

There is an overarching methodology of three *primary* data collection methods, backed up by *secondary data review*.⁸

The three *primary* data collection methods are:

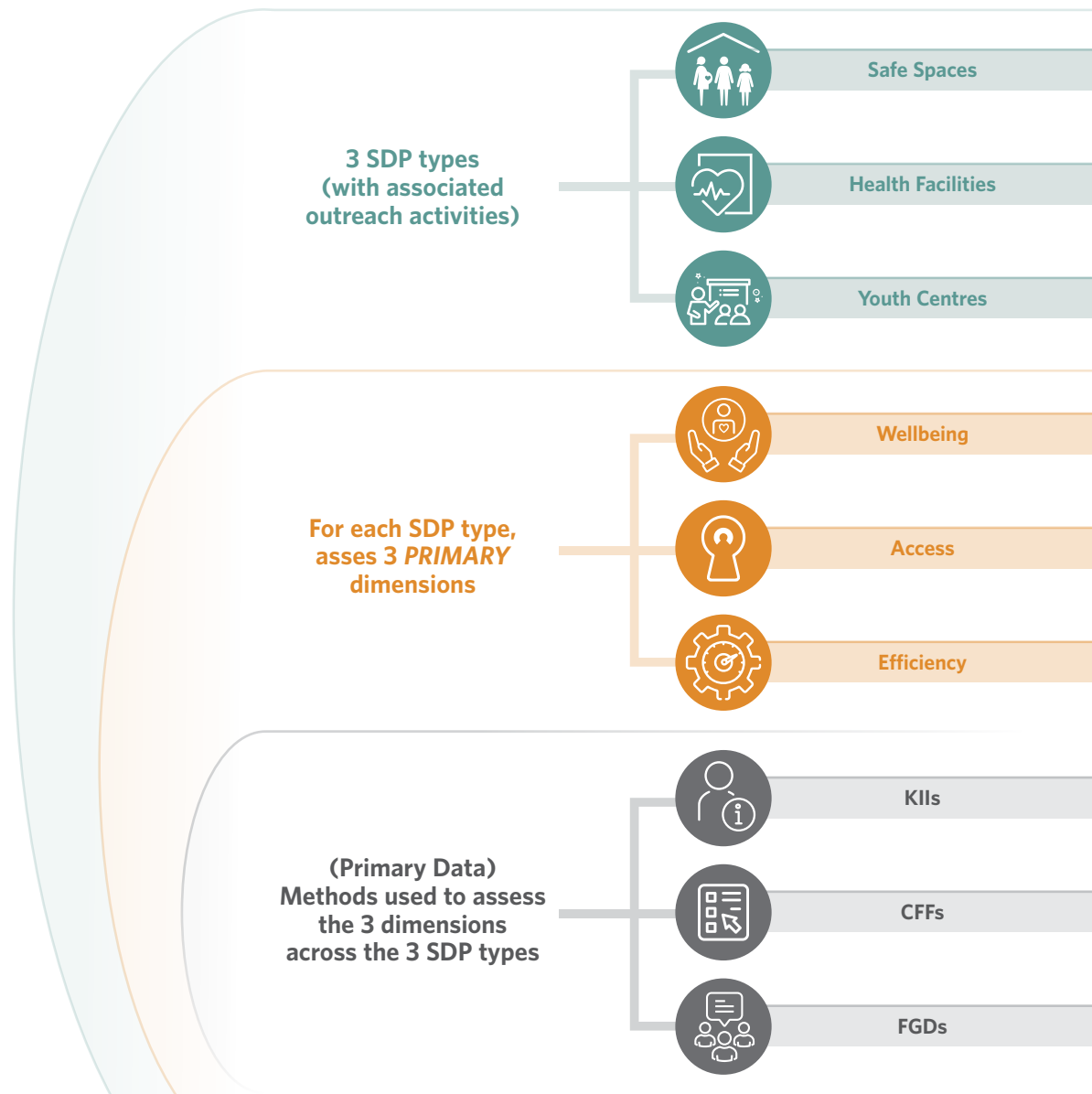
- a. Key informant interviews (KII);
- b. Client feedback form (CFF);
- c. Focus group discussion (FGD).

⁷ For secondary data the reporting period is 1 October 2021 to 1 October 2022.

⁸ Note that the 2021 Assessment included a significant in-depth document review. The 2022 Assessment will build on this comprehensive document review, adding a further document review of any new secondary evidence from the last year.

The following represents this approach to data collection graphically⁹

Figure 1: Data sources and analysis dimensions



Data cleaning, coding, and analysis

Quantitative data (Client Feedback Forms)

On finalisation of the quantitative data collection tool (CFFs), the assessment team developed appropriate coding guides in MS Excel. Data was transcribed into this format. Descriptive analysis disaggregated by the relevant subgroup/SDP (GBV/SRHR/Youth), country and other relevant disaggregations as deemed useful or relevant (e.g. age, gender, disability status) was completed in MS Excel.

⁹ It is noted that for the Turkey country programme the Safe Spaces are integrated into the health system and provide both SRHR services at primary health care level and GBV services.



Data from open ended questions in the CFF was manually coded into a custom series of categories for each question developed using inductive coding.¹⁰ All data was then assigned to one of these codes and analysed quantitatively via MS Excel (cross-tabulations/disaggregations via use of pivot tables).

Qualitative data (FIIs, FGDs)

Two sets of coding took place. First the KII/FGD notes were coded to specific sub-questions and topics within these questions, highlighting key information following each interview by prescribed theme and summarising essential information, findings, and issues to further pursue. As a second step, the raw data was cleaned and entered into the data entry code sheets, again in MS Excel.

At the end of the data collection period, findings under each of the assessment questions were summarised and shared among the evaluation team. The assessment team conducted multiple reviews of data on a rolling basis as data collection was completed, as well as at the end of the data collection period.



¹⁰ Inductive coding and creates codes based on the qualitative data itself developed via an iterative process of reviewing the data and assigning codes/categories that fit best for most of the dataset.

Learning from the 2021 Impact Assessment:

There were some specific lessons learned from the 2021 Impact Assessment which were used to refine the methodology for 2022. These lessons and the proposed changes made to the 2022 methodology are outlined in the table below.

Table 3: Lessons learned from 2021 Impact Assessment and proposed changes for 2022

Lessons learned from 2021	Explanation	Changes for 2022
More focused CFFs	Some CFF questions (e.g. related to COVID-19) were duplicative and did not generate significant useful data.	Reviewed the CFFs to better meet data needs. Countries/operations to share amendments during the planning phase.
Limited sample size for quantitative data collection [CFFs]	The sample (number of forms) should be representative (CI: 95%) of the entire population of beneficiaries it represents, including sub-populations (e.g. male vs female; ensure enough male beneficiaries actually complete the CFFs)	Adequate sample calculations for CFFs, with focus on sub-populations. This was done with online tools like Raosoft .
Harmonisation of datasets during data collection/entry and transcription.	Some datasets transcribed by operations/countries did not fully align with the data entry templates, necessitating labour-intensive manual reorganisation and recoding, increasing risks of errors in analysis.	Improved harmonisation across participating countries/operations by [a] better training on data collection happens and [b] data collection/entry tools are aligned.
Paper-based data collection affecting data quality, especially for CFFs	Data collection should be digital if the context allows. Paper-based data collection, with handwritten notes, complicates data processing, cleaning and analysis.	Countries/operations continued with digital data collection and initiate digital data collection where possible.
More time required for FGD data collection.	FGD data collection was challenged by limited time, while UNFPA's partners need to properly prepare for these discussions. There are also related risks as not being able to identify sufficient participants.	More time was allocated to the FGD data collection, so countries/operations can plan within a longer timeline.
More explanation on the data analysis in the methodology section of the final Impact Assessment report	As one important component of looking at the findings is to understand how the data was collected and analysed, there is a need to further elaborate including the strengths and weaknesses, similar to academic papers.	Improved the methodology section in the final report.
Country specific recommendations are missing.	The 2021 Impact Assessment contains region-wide recommendations. Countries/operations have requested to include more specific recommendations for each context in 2022.	Included country/operation specific recommendations in the 2022 Impact Assessment report.
Better inclusion of men/boys during FGDs.	Some countries/operations did not sufficiently engage with boys and men during FGDs.	Organised nine FGDs with male beneficiaries.

Lessons learned from 2021	Explanation	Changes for 2022
Data collection could be facilitated by external and so more independent consultants to avert interviewer bias.	Most of the data from the 2021 Impact Assessment was collected through UNFPA (partner) staff which may affect the information being reported by the respondents.	Where possible engaged consultants in the data collection, e.g. third-party monitoring (TPM).
More focus on UNFPA's 3 transformative results	The data collection tools aimed to obtain perceptions from UNFPA beneficiaries and from those supporting the implementation of UNFPA programmes across three key dimensions; wellbeing, accessibility and efficiency. These relate to the 3 transformative results, but better alignment can be aimed for, including data analysis and synthesis.	Kept the 3 transformative results in mind during data collection tools review, data analysis and formulation of findings and recommendations. Although, acknowledging the current scope of the Impact Assessment.

Report Structure

Given the depth of the data, this report is presented in 2 volumes.

- **Volume I:** this volume includes Sections 1-3. This is the introduction and methodology; the regional impact assessment findings; and the regional impact assessment conclusions and recommendations.
- **Volume II:** this volume includes Section 4 of the report and consists of the country level findings.



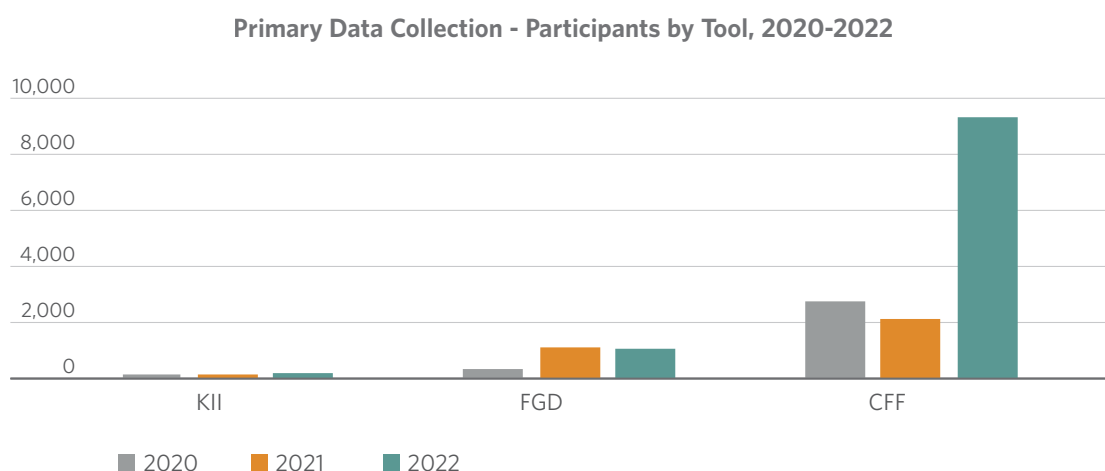
THE 2022 IMPACT ASSESSMENT INCLUDES INPUT FROM 177 KEY INFORMANTS; 1,061 FGD PARTICIPANTS; AND 9,294 CFF RESPONDENTS.



Data Sources

The 2022 impact assessment includes input from 177 key informants; 1,061 FGD participants; and 9,294 CFF respondents. This represents a very substantial increase in the number of CFFs being returned for 2022, with increases in KIIs reflecting the additional two countries, and a slightly fewer participants in FGDs than 2021, although this represents a negligible (i.e. <4%) difference.

Figure 2: Data Collection - Participants by Tool 2020-2022



The impact assessment also included over 100 documents reviewed, together with a re-review of the extensive document review conducted for the 2020 and 2021 impact assessments.

The charts, right, display the evolution of data collection between the 2020 report and 2022, with a substantial increase in the numbers of people responding to the CFF (by almost five-fold) in 2022, providing a much more robust sample of data and hence findings, particularly when analysed at individual country level.¹¹

Key informants were drawn from UNFPA institutional stakeholders: IPs, SDP staff members and UNFPA country-based staff, to provide contextual detail on programmatic achievements, challenges and constraints.

As illustrated in the charts below, FGDs were held with (mostly) women/girls. A small sample of men attended SDPs in four of the countries, and for the first time, a group of female transgender participants attended in Lebanon. Addition of members of this vulnerable community in research is not just an important milestone in data collection terms, but a commendable step in overall inclusivity.

¹¹ Please note that in all charts, "Türkiye XB" refers to Türkiye cross-border programme.

Figure 3: Key Informants by Organisation

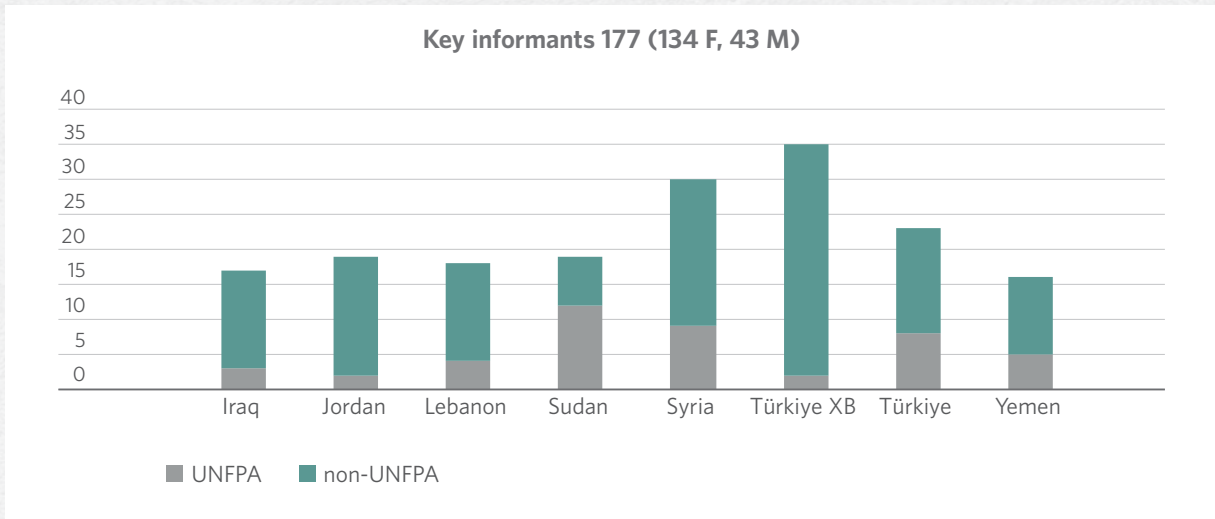
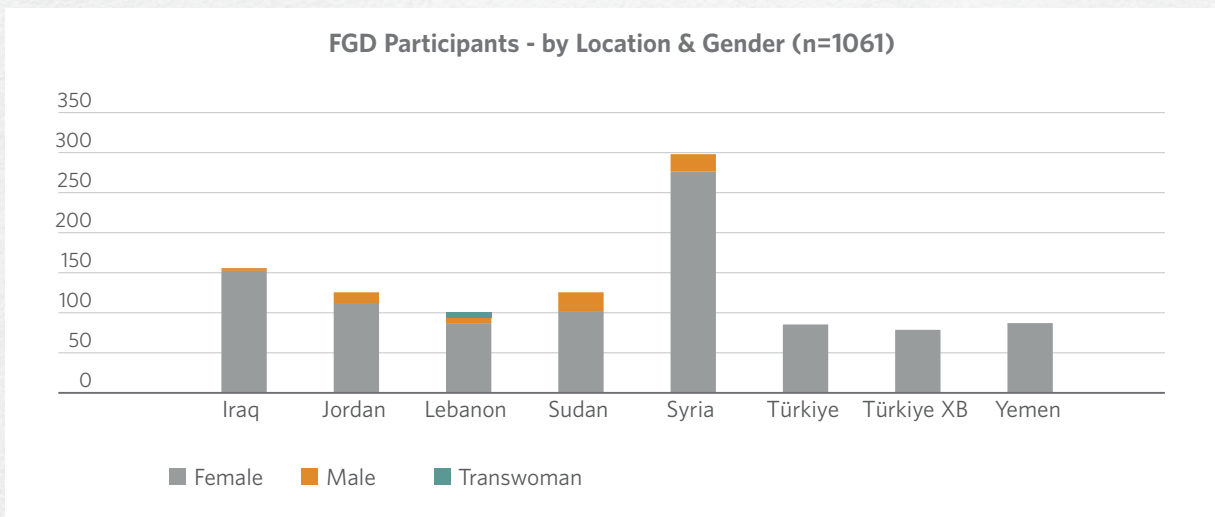


Figure 4: FGD Participants by Location and Gender



Finally, a record number of CFFs were completed for 2022, with a suitable breakdown across the three types of services delivery points (GBV/SRH/youth) and by age, to ensure full representation across peoples’ needs and profiles. This permits the analysis to generalise with a high degree of statistical confidence (i.e. findings are within 95% confidence intervals and 10% margin of error) across programmes and within subgroupings such as age groups (except where limited numbers of population sub-groups were represented, such as the low number of adolescents (3) participating in the Türkiye cross-border programming CFF data collection).¹²



FINALLY, A RECORD NUMBER OF CFFS WERE COMPLETED FOR 2022, WITH A SUITABLE BREAKDOWN ACROSS THE THREE TYPES OF SERVICES DELIVERY POINTS (GBV/SRH/YOUTH)

¹² In 2022, the TXB programme integrated CFF questions in its ongoing TPM exercise. While this has enabled TXB operations to collect data and information on the quality, accessibility and relevance of the services provided, the number of forms are not sufficient to reach a representative sample size for the purposes of this assessment.

Figure 5: FGD Participants by Age Range and Location

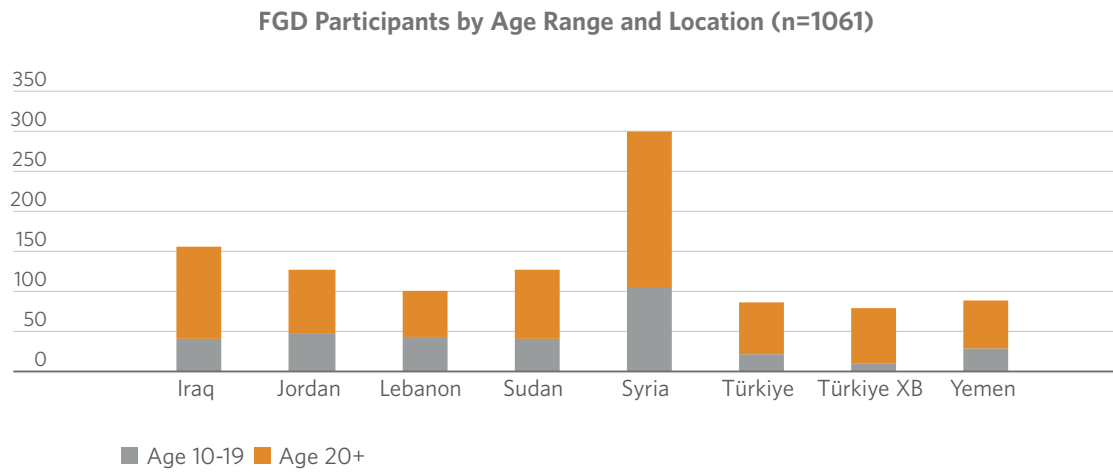


Figure 6: CFF Respondents by Location and Age Group

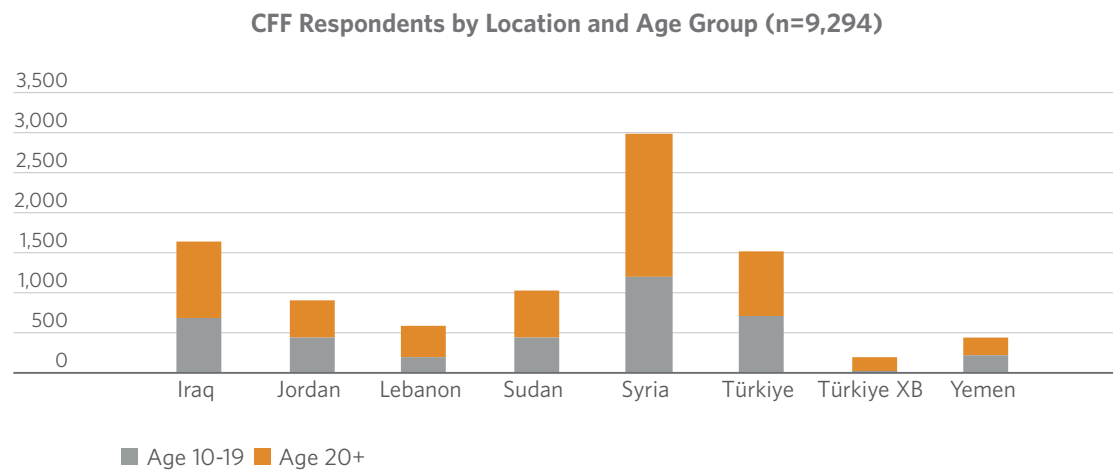
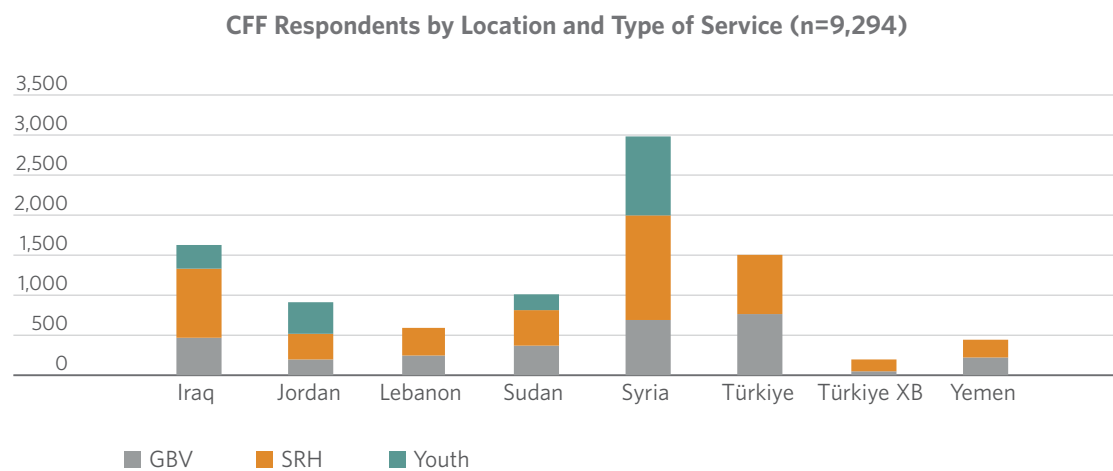


Figure 7: CFF Respondents by Location and Type of Service



A woman wearing a black headscarf and a red and white patterned top, looking out from a window. The window frame is made of light-colored wood or plaster, and the wall to the left is weathered and peeling. The woman's hands are resting on the windowsill.

Section 2.

Regional Impact

Assessment Findings

Section 2. Regional Impact Assessment Findings

UNFPA country and cross-border programmes seek to support a wide range of programmes and interventions across the three mandate areas of SRHR, GBV and youth. That said, each mandate area does not receive the same level of attention across all countries. SRHR receives most attention, followed by GBV, with youth services, in general, receiving the least attention – for example humanitarian youth programmes are not supported in **Jordan, Lebanon, Türkiye cross-border** and **Yemen**. In these, and other, countries, such as Iraq, youth programming is integrated into the other mandate areas, rather than specific standalone programming, or has transitioned across to longer-term development programming. In many countries, services delivered via Safe Spaces have specific youth activities, for example in **Iraq** UNFPA supports specific sessions for young girls within camp-based Safe Spaces. In other countries, e.g. **Yemen**, GBV programming is not fully tolerated by the government authorities, especially in areas under the control of the de facto authorities, hence the comparatively lower attention.

The four youth centres reported in **Türkiye** are supported with donor funds that are not part of the regional programme, hence are not specifically reported on in this assessment. In Türkiye, the service units are tailored to the needs of different vulnerable groups, including women and girls, youth, key refugee groups (including LGBTQI refugees, refugees living with HIV, sex workers), men and boys survivors of and/or at risk of GBV, refugees with disability, women survivors of GBV. This means that the business model of each service unit is unique in terms of targeted population and provided services. Starting with 2022, all UNFPA supported service units, regardless of their targeted populations, are providing GBV services along with SRHR counselling and services at primary health care level. Moreover, youth interventions are embedded in the services provided by all supported service units. The youth centres are the ones providing a more focused response.



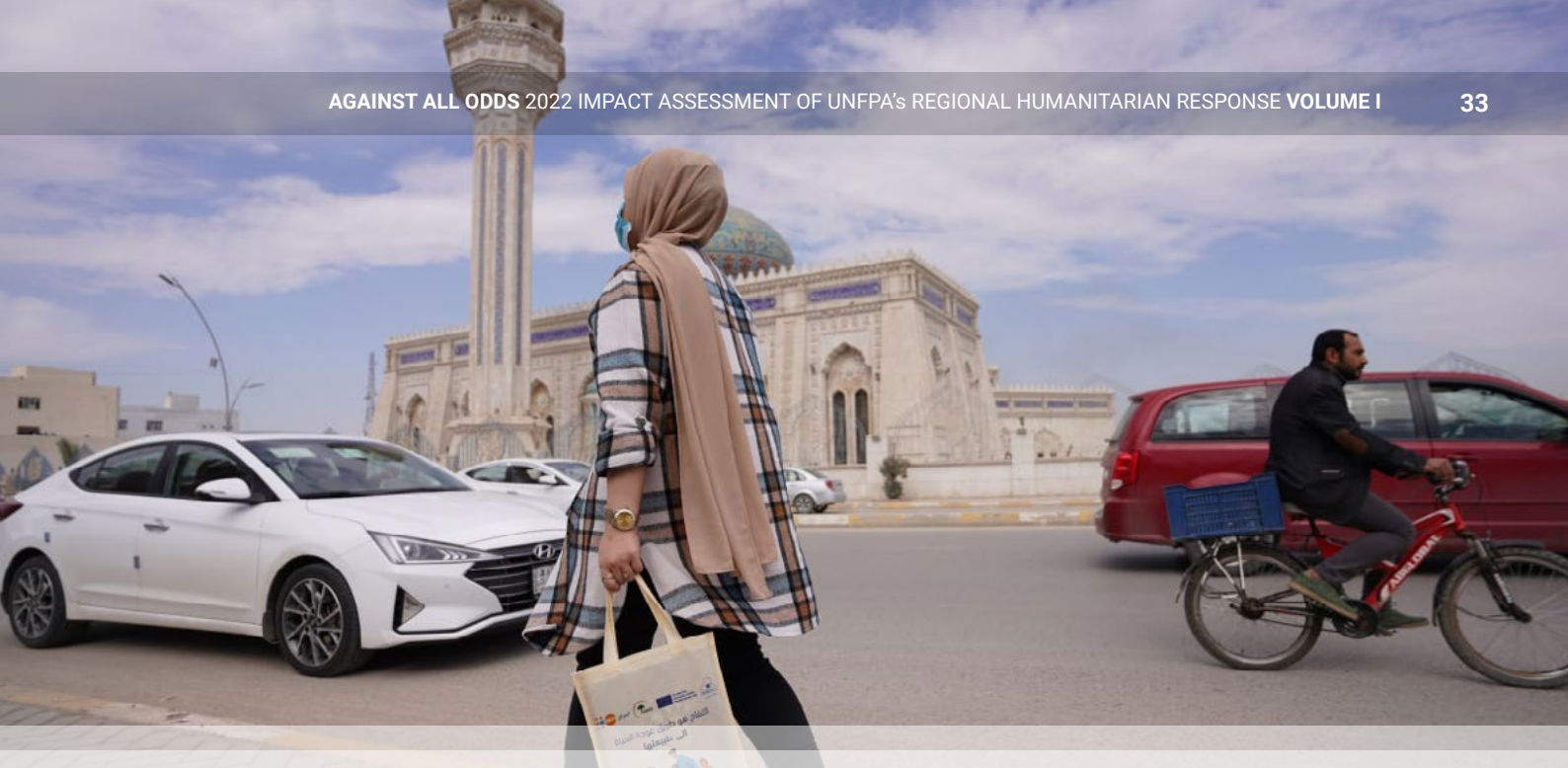
Notwithstanding this programmatic overlap in places, beneficiary-focused UNFPA-supported humanitarian programming takes place across three main SDPs: GBV (Safe Spaces),¹³ SRHR (health facilities), and Youth (youth centres or youth-friendly spaces) which are analysed separately below.

DIMENSION A: Wellbeing

This dimension of the humanitarian response work that is being undertaken by UNFPA looks at the physical and psychosocial wellbeing of those at risk of GBV and GBV survivors and those in need of SRH or youth services. Data was collected to assess respondent perceptions on the following key points:

- a. The range of services/activities provided at UNFPA-supported facilities.
- b. Any desired changes or additions to services.
- c. Importance of and reasons for attending services.
- d. Satisfaction with/impact of dignity kits.
- e. Feelings of safety and respect in services and providers and feedback mechanisms.
- f. Contributions of services to UNFPA's mandate areas.

¹³ Also known as Women's Centres (Sudan), Women's Health & Counselling Centres (Türkiye – WHCC are established within Migrant Health Centres (MHCs) of the MoH) or Community Well-being Centres (Syria)



GBV Programming

a. The range of services/activities provided at UNFPA-supported facilities.

UNFPA supports several hundred GBV SDPs via its humanitarian programming across the participating countries that provide a range of empowerment, support, case management, training and social activities to thousands of women and girls. While the number of actively-supported SDPs varies over the course of time (in **Türkiye**, for example, most Women and Health Counselling Centres – and other service units – were, at the time of research, in the process of being handed over to government management by UNFPA), as of mid-2022, a total of 225 Safe Spaces were being supported across the eight humanitarian operations. This represents an increase on the 2021 numbers (144 Safe Spaces were supported in 2021 across the six operations, 155 in the same six operations for 2022), with increases seen in **Lebanon, Syria, Türkiye** and **Türkiye cross-border**, though a decrease in **Jordan**.

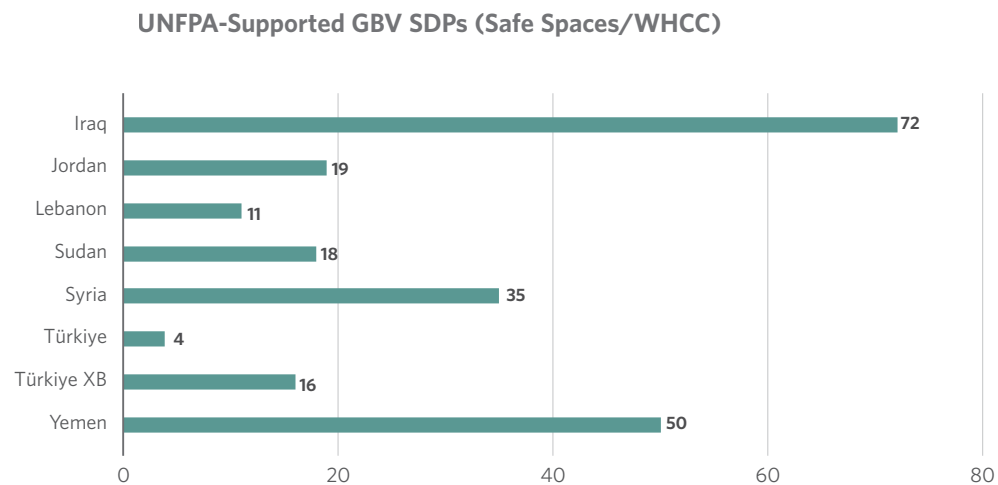
In **Iraq**, UNFPA is currently piloting the transition of strong Safe Spaces from humanitarian to longer-term development settings. One Safe Space in each of the cities of Mosul (held by the Islamic State between 2014 and 2017) and in Baghdad will be supported by UNFPA over the coming year until they can operate independently of UNFPA support.

GBV SDPs typically undertake a very wide range of activities – within a given safe space or centre, across a particular country, and across the different national humanitarian responses undertaken.

Although not exhaustive, most types of activities undertaken can be grouped in the following categories:

- Vocational training (sewing, handicrafts, beauty/hairdressing, trades, computers)
- GBV case management/psychosocial support (PSS)
- Awareness raising on GBV, rights or other issues
- Social, cultural and recreational activities (including physical activities)
- Education, language and literacy training
- Health promotion – both general and specifically related to SRHR
- Life skills training (communication, relationships, drugs, health)
- Legal advice
- Youth/adolescent-specific activities

Figure 8: Humanitarian GBV SDPs 2022



The specific activities chosen at the centres are generally done so on the basis of consultation with the community members who attend, so as to reflect the highest priorities among them. Staff or IPs typically adopt a variety of consultation methods that reflect appropriate social norms and types of communication channels, such as:

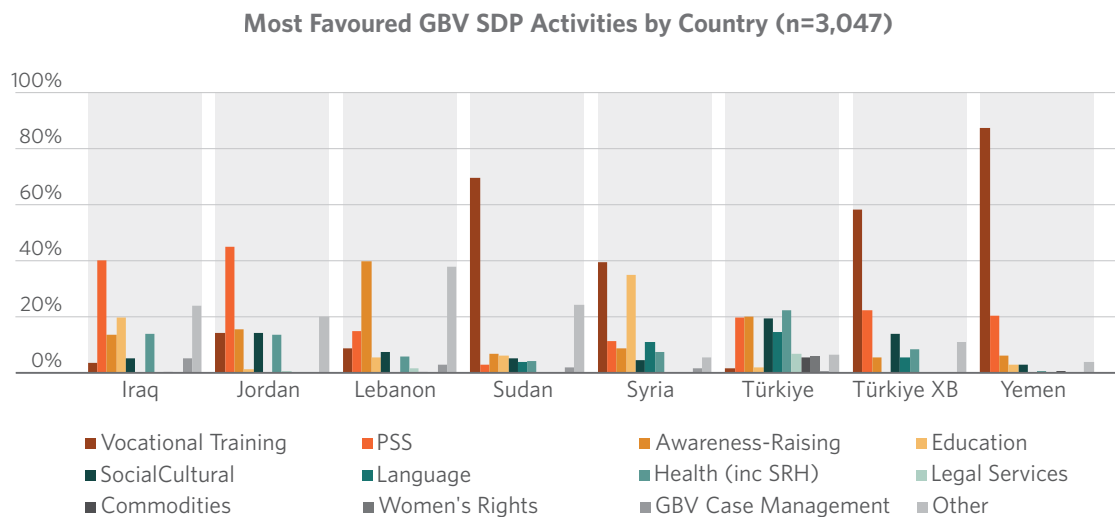
- Periodic FGDs (**Iraq, Türkiye**)
- Social media (Facebook, WhatsApp groups, IP websites) (**Iraq, Jordan, Lebanon, Syria, Türkiye cross-border**)
- General consultation between the centre staff and members (all)
- Advocacy/outreach amongst communities (**Jordan, Türkiye cross-border, Türkiye**)
- Telephone outreach (**Lebanon, Jordan**)
- Polls among members on a 'menu' of potential services created by centre staff/IPs (**Lebanon, Sudan, Yemen**)
- Requests from persons who have attended sessions at earlier times. (**Sudan**)
- Consultation with community leaders and/or government officials (**Sudan**)
- Surveys (**Syria, Türkiye cross-border**)
- Suggestion boxes (**Syria, Türkiye**)
- While some attendees at the centres, in FGDs, noted that they either didn't know how activities were chosen, or they felt that the activities were pre-chosen, these were in the minority, and it is clear from the overwhelming majority of responses that these SDPs adopt a participatory approach to selection of the types of activities undertaken, to ensure that they reflect what women and girls both want and need.

"[We recruit attendees] through advertisements on Facebook. And then we enrol through our friends, our husbands and fathers as well as the team from the centre who visit houses and the surrounding area."

– (FGD Participant, Iraq)

The most popular activities undertaken in GBV SDPs vary considerably across countries, as presented in the chart below. In general, vocational training was the clear favourite in Sudan, Syria, Türkiye cross-border and Yemen, with PSS the favourite in Iraq and Jordan, and awareness-raising (on such topics as GBV, child marriage, women's rights) the most popular in Jordan, but a significant preference in other countries also. In Türkiye, preferences were more evenly spread across a variety of categories.

Figure 9: Most Favoured GBV SDP Activities by Country



While GBV case management is not rated as one of the most popular activities, most attendees at the centres do so for training or general support and do not need to avail of such services, reflected in these results, although it is interesting to note that GBV case management is the second-most popular activity (after PSS) in Iraq. Voices from women and girls directly, via FGDs, attest to the importance of these centres in providing safe and secure spaces in order to be able to talk, socialise, support each other, to learn, and in some cases, provide relief from the troubles and stresses of life.

“For me, one of the best things in this centre is that there are no boys nor men.”

– (FGD participant, Jordan)

“The centre is like a family for us.”

“I find the centre comfortable and safe.”

“The Electricity at Home course was provided for widows and divorced women, as they can't let any stranger enter their house. Now they can repair for themselves and help others.”

“I love all the services of the centre because this camp feels like a big prison.”

– (FGD participants, Syria)

Attendees at Safe Spaces were also asked what were the **least** relevant or important activities within their space. Of the participants in the survey, 75% declined to answer this question, as they felt all activities were important or couldn't think of any that were so. Feedback from women and girls suggested that they were **not** in favour of specific activities primarily for personal reasons – either they lacked interest in a particular topic, in some cases people already had the skills (e.g. literacy, languages) and in others people felt they were incapable (mainly around physical activities like sports or in some cases technical skills like trades – e.g. electricity, carpentry).

There were some interesting responses around people's capacity to engage in certain activities, whether due to their physical or mental capacity to do so, or due to wider determinants such as the availability of materials, or even the likelihood of generating an income from a training activity. Age was a factor in many responses, particularly around computers, sports and some cultural activities. Some specific responses from participants as to the challenges they faced in certain activities are as follows:

- Sports: we are physically disabled. (Iraq)
- Sewing: due to our old age, it is difficult for us to learn it. (Iraq)
- Stove making: there is low demand. (Sudan)
- Soap making: lack of raw materials in the local market. (Sudan)
- Handicrafts: demand is low and the financial return is weak compared to effort and time. (Sudan)
- Learning computer skills: without a device to practice on at home, it would be a waste of the skills I learnt. (Syria)
- Theatre: it was aimed at young people, not me. (Türkiye)
- Making accessories: they don't generate a lot of profit and require a lot of work. (Yemen)

This feedback suggests that there are opportunities for GBV SDPs to learn from the feedback mechanisms in place about what is useful for attendees at the centres, particularly around making sure there are activities that are suitable for vulnerable groups such as PWD (almost half of all respondents self-reported experiencing some disability).

b. Any desired changes or additions to services.

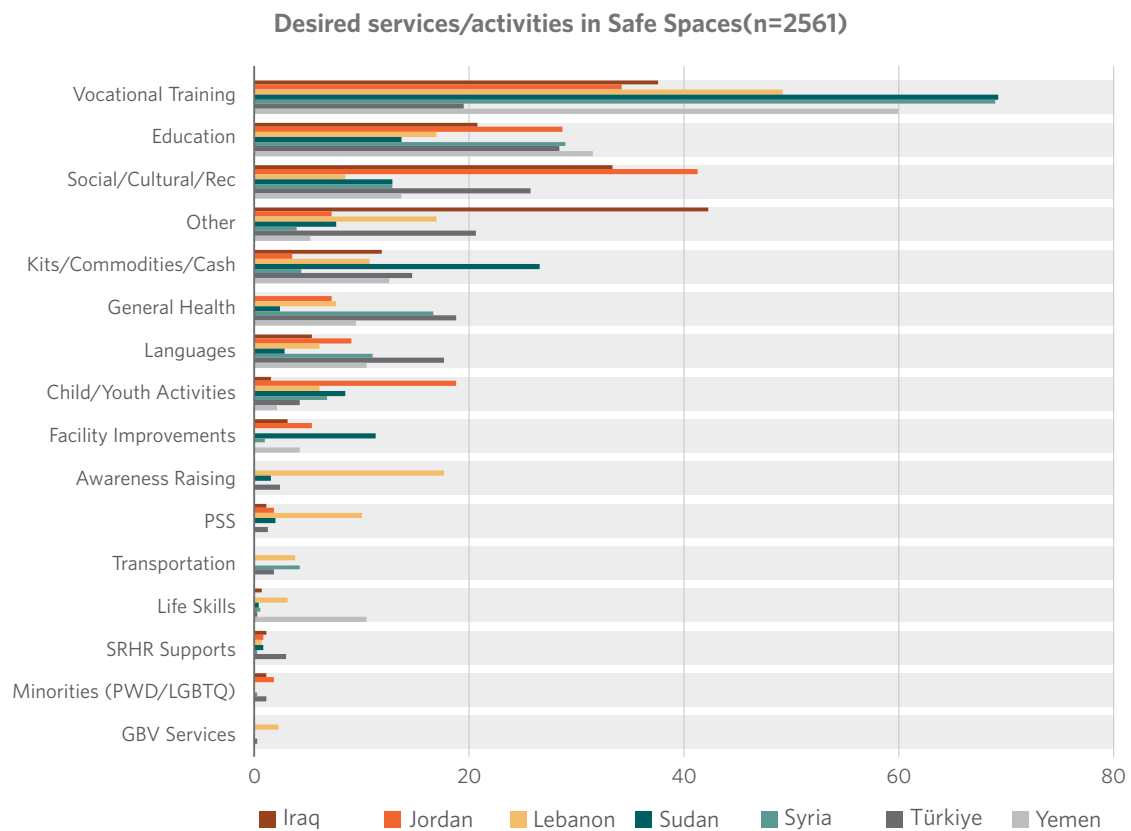
Women attending Safe Spaces or women's centres were asked for their feedback on any changes that they would like to see with respect to the services offered. As presented in the chart below, the greatest number of recommendations were with respect to vocational training, education and in social/recreational activities. The high popularity of vocational training is a reflection of the ongoing economic challenges faced across the participating countries, with many women noting the importance they ascribe to being able to earn some income to contribute to their household economy. Some examples across the different countries on things that could be improved within Safe Space activities are:

In **Iraq**, women felt that training courses should be continuous and to last for a longer period of time.

The increased cost of transportation was a major issue noted across all countries. Women highlighted that people living in more remote rural regions have difficulties in accessing the centres.



Figure 10: Desired Services in GBV SDPs by Country



In **Lebanon** (which was unique in conducting a FGD wholly with transwomen) recruitment of transwomen as employees within the Safe Spaces was requested due to the discrimination they face in gaining employment.

Women in **Syria** requested small grants to start their own business after graduating from the vocation training courses offered.

Syria, Lebanon and **Sudan** all requested provision of fuel for electricity generators which are needed to compensate for shortage in municipal electricity supplies.

The chart below provides some additional detail on the types of vocational training that were requested directly by women at the centres (**Türkiye cross-border** did not request this information). There is a relatively wide variation amongst the different categories specified (albeit by relatively few respondents – only approximately 20% of relevant survey participants responded to this question with a specific preference). Respondents in **Iraq** and **Türkiye** had a clear preference for training on specific trades (e.g. electrician, carpenter, mechanic, driver), whereas **Jordan** and **Syria** had a similar preference for hairdressing/barbering or beauty training. In **Lebanon, Yemen** and **Sudan**, preferences were more evenly spread across all categories.

The relatively high interest in trade-based vocational training activities is an interesting phenomenon, potentially reflective of changing gender norms – indeed, in 2021, UNFPA **Jordan** noted introducing some of these activities in an active attempt to seek to be more gender transformative in its programming. Although a third (30%) of respondents to the survey noted interest in trade-based activities, the majority of women and girls in **Jordan** (61%) still opted for more gendered activities of hairdressing/barbering or beauty training.

Figure 11: Desired Vocational Training Activities in GBV SDPs by Country

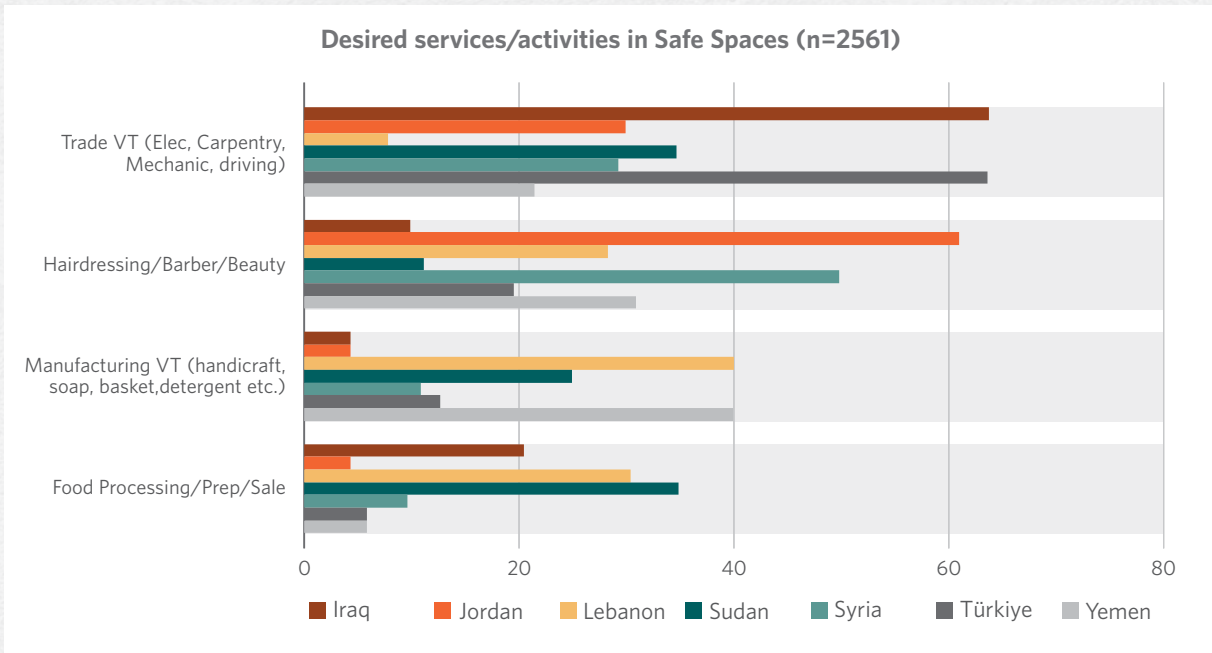
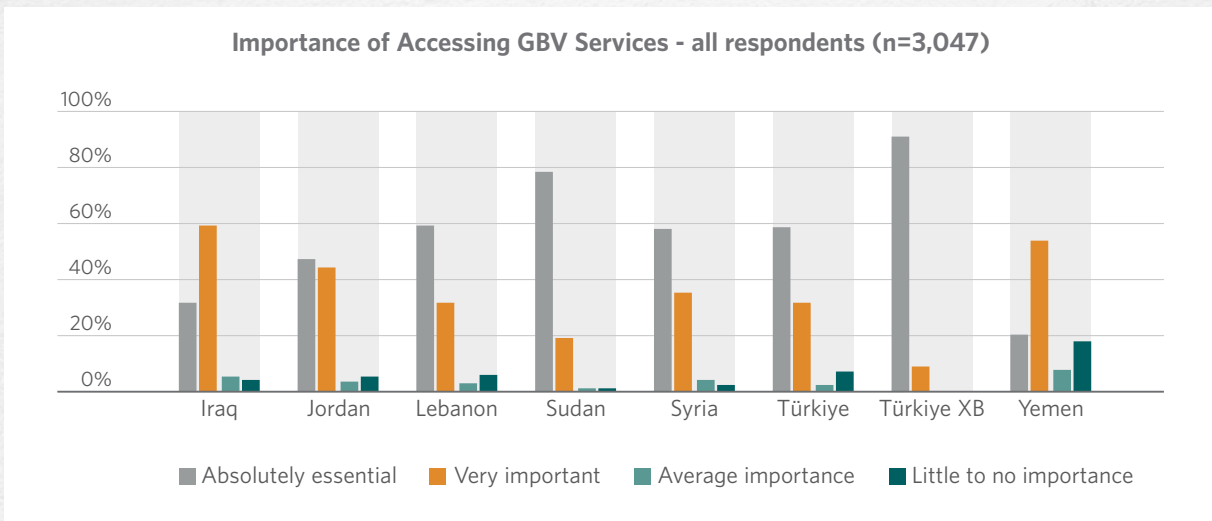


Figure 12: Importance of GBV Services by Country



c. Importance of and reasons for attending services.

Attendance at Safe Spaces was universally highlighted by women and girls to be of vital importance to their wellbeing and mental health. The chart, right, presents responses from women attending GBV services on their perceived importance of the facilities. It is clear that almost all consider them to be of substantial importance, with **Türkiye cross-border** and **Sudan** respondents ascribing the service very high value.

Participants in discussions noted the most common reasons for coming to the centres as psychosocial support and stress relief/a feeling of safety, followed by training/learning new things and socialising with friends or other social or recreational activities.

"We come to the centre to escape the pressures at home, the pressure of life, the violence to which women are subjected to and the difficult circumstances we suffer from. Awareness sessions helped us in changing a lot of misconceptions, and we learnt about women's rights in cases of divorce and how to demand those rights."

– (FGD participant, Iraq)

In **Jordan**, women in refugee camps highlighted the relief from stress and family pressures that Safe Spaces afford, the ability to share traumatic issues in confidence, access assistance for children, peer encouragement and recreation.

"I can speak freely here about things which are impossible to tell anyone outside the centre, even my sister."

In **Lebanon**, women and girls highlighted recreation, learning, relief of stress and family problems, awareness-raising and the ability to access emergency financial support if experiencing GBV.

"You feel that you are doing something new for yourself and your family. You learn so many new things, such as self-protection and resilience."



Sudan women and girls noted the value of awareness raising and education, building marketable skills, recreation, and the transfer of guidance from older mothers to younger.

Participants from **Syria** and **Türkiye** highlighted language lessons (in English and Turkish, respectively), vocational skills, stress relief/PSS (particularly with centre staff), self-confidence/esteem building, medications and treatment (including hygiene and sanitary commodities), recreation, vocational training and friendship building.

"At first, I came for the recreational services, but when the other courses started, I registered and the staff helped me to choose the course, and today I feel empowered and valued."

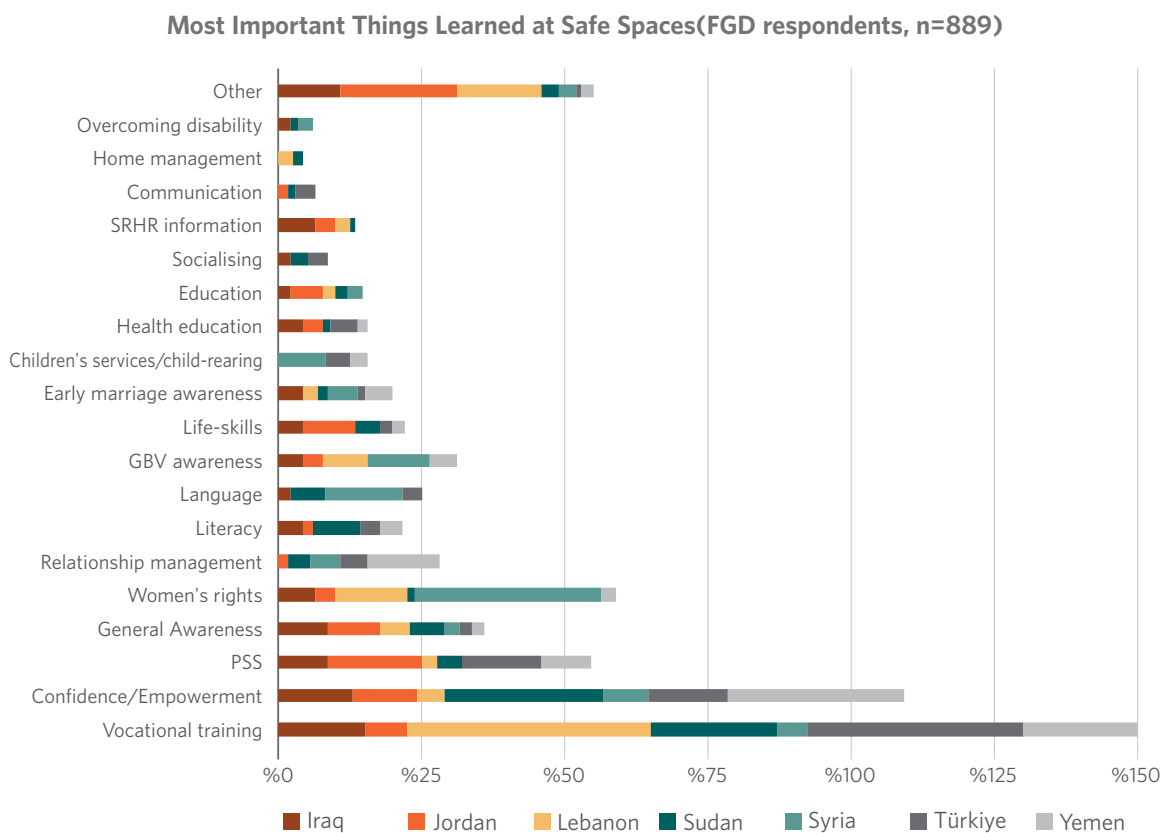
"I spent years at home after my parents made me drop out of school. The first time I went out was to the centre and it has changed everything in my life"

– (FGD participant, Syria)

"I came to improve myself and to get stronger. They teach everything here, so I feel more resilient. How should I act when something happens? How do I become self-reliant? For me these are very important questions. I come here for these reasons."

– (FGD participant, Türkiye)

Figure 13: Most Important Things Learned at Safe Spaces/Women's Centres by Country



In **Syria**, a 2022 evaluation of joint UN programming (including UNFPA-supported work in Safe Spaces) highlighted the value of Safe Spaces in peacebuilding and recovery in bringing together women from different neighbourhoods in Dara'a and forging strong relationships and friendships among them.

Women in **Yemen** emphasised learning, life-skills, self-reliance, PSS/stress-relief, vocational skills, legal advice and literacy.

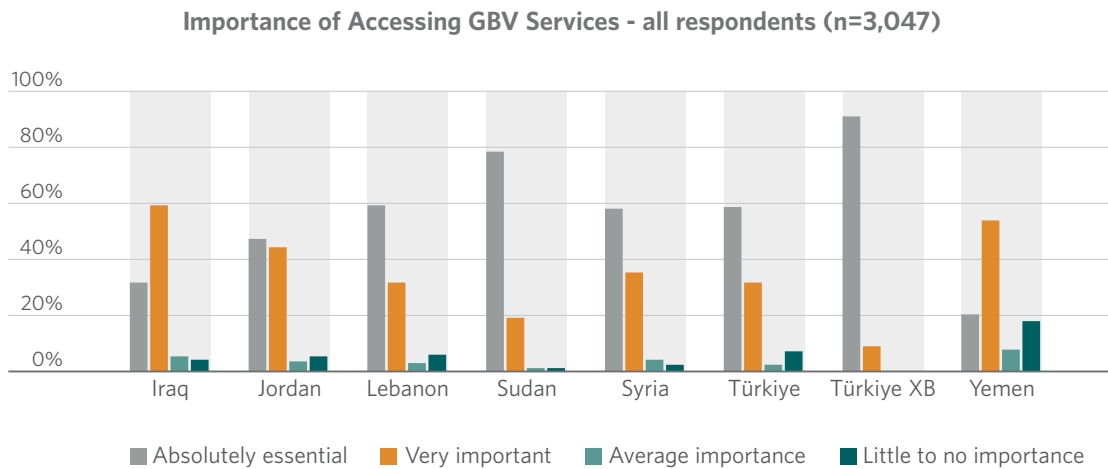
“Sitting at home is exhausting and pointless, but the safe space changed my mood and I gained new experiences and skills.”

— (FGD participant, Yemen)

The chart, right, presents an analysis of the most important things reported by women and girls to be learned at the centres they attended. Interestingly, while vocational training rated very highly across most countries (less so for **Türkiye** and **Lebanon**), confidence and empowerment was a close second, with PSS, women's rights and general awareness activities next most popular.



Figure 14: Importance of Accessing GBV Services by Country



Notwithstanding the high priority placed on various vocational and social activities within GBV SDPs, the importance of being able to access GBV services was underscored by the vast majority of women participating in the assessments. The charts, below, illustrate this.

Over 90% of all respondents across the region felt that being able to access GBV services in Safe spaces was either absolutely essential or very important. Respondents in **Türkiye cross-border programming** and **Sudan** were particularly emphatic in this regard, with 91% and 79% of each deeming the services essential, respectively.

It was an important step in my life because I dropped out of school, we were displaced, our parents prevented us to go to school fearing kidnapping and bombing and lack of safety, and my mental state was bad. When I came to the centre, I started gaining new experiences, training in a career and I felt relaxed. By attending hairdressing and sewing sessions, I have gained hope. The courses have improved my life psychologically, financially and morally.

– (FGD Participant, Türkiye cross-border programming)

Respondents in **Yemen** were somewhat more equivocal in their responses, with 21% of them deeming services essential, 54% as very important and a quarter (26%) considering them average or no importance, perhaps reflective of discriminatory gender norms that are still highly prevalent in Yemen.

Testimony from women and girls themselves makes it clear the ongoing importance in which such services are held by women – even if not all women will need to avail of them. A vital consideration is that such services are unavailable elsewhere to women in most of the countries, and UNFPA therefore supports lifesaving activities that would not otherwise exist.

“Its importance lies in making us more self-confident. We receive the attention we need, as people listen to our problems and give us guidance. This helps us to control the pressures we face, because we have been surviving inside tents for a long time and coping in difficult living conditions.”

– (FGD participant, Iraq)

“If the centre didn’t exist I would stay at the house all day due to my disability, like I used to. I felt like I was buried but now light has returned to my life since attending the centre.”

– (FGD participant, Syria)

"Case management and psychological support made a new person out of me."

— (FGD participant, Syria)

"[The centre] is important because it strengthened my self-confidence and taught me my rights. I know now that I am strong and able to hold on to my goal no matter the circumstances."

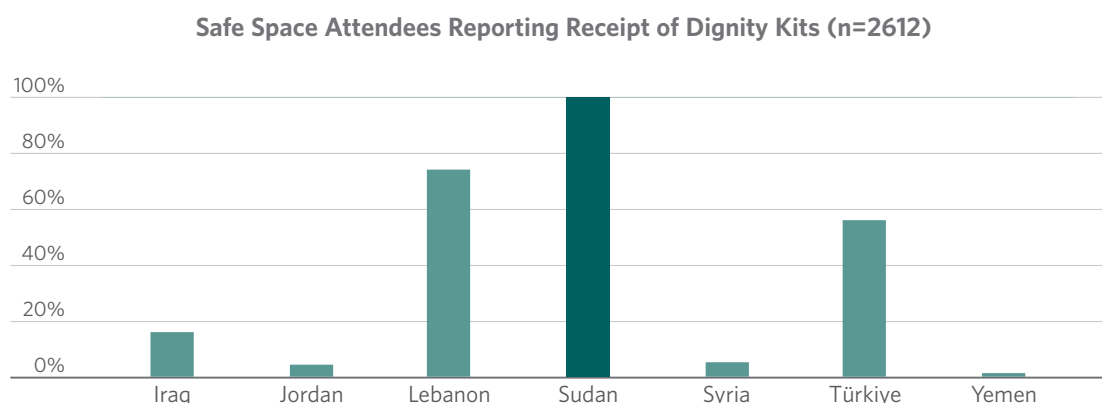
— (FGD participant, Yemen)

d. Satisfaction with/impact of dignity kits.

Dignity kits are a critical and longstanding component of the UNFPA humanitarian response, helping women and girls maintain proper hygiene after being displaced.

UNFPA and its partners have recognised many benefits of dignity kits over the years, such as minimising the perception among women and girls that they are forgotten or side-lined in humanitarian responses. They also provide useful incentives to attract women and girls to other services. While UNFPA maintains a global basic standard dignity kit template, dignity kits are usually contextualised to the specific cultural and climatic situation.

Figure 15: Safe Space Attendees Reporting Receipt of Dignity Kits by Country



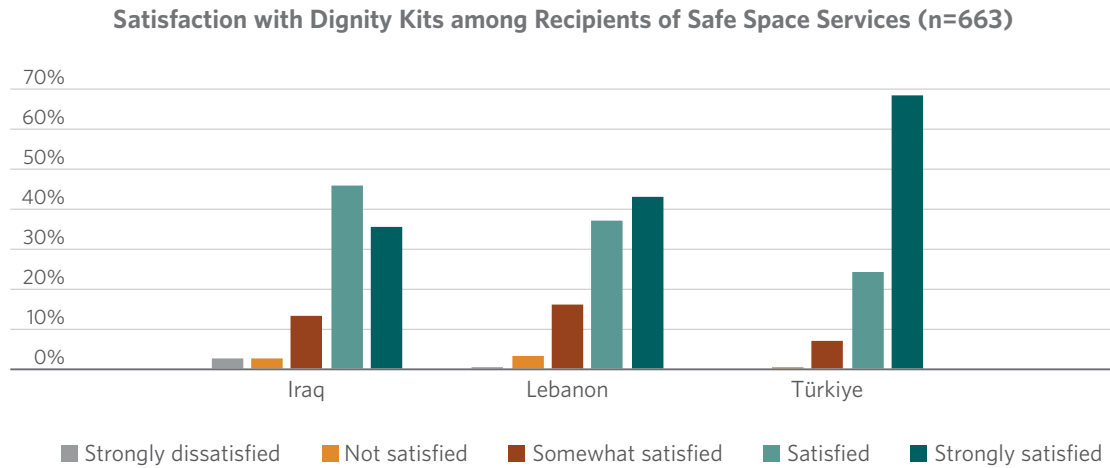
In many operations, UNFPA uses Safe Spaces as distribution points for kits in most operations. This is a useful approach to both ensuring that women and girls obtain these increasingly essential and difficult to purchase items, and to link the distributions to provision of services, e.g. awareness sessions. **Jordan**, in particular, noted that this approach results in high attendance at events/sessions.

Over the course of three months preceding the research (roughly April-June 2022), at least 740 women attending seven of the participating humanitarian operations reported receipt of kits (presented in the chart, above – note that UNFPA Sudan distributed kits to Women's Centre attendees, but did not record numbers of those in receipt for this assessment), although the proportion of women in receipt varied greatly from 74% (**Lebanon**) to 1% (**Yemen**).¹⁴ Satisfaction with the dignity kits was very highly rated by these women and girls, as shown in the chart, right (countries without a robust sample size were not included in this analysis). More than 80% of women across the countries included in the analysis expressed that they were either strongly satisfied or satisfied.

¹⁴ Sudan and Türkiye cross-border did not ask women about the receipt of dignity kits and only three respondents from Yemen, nine from Jordan and 37 from Syria reported receiving dignity kits so have not been included in the analysis due to lack of statistical robustness.

Dissatisfaction with the kits themselves was rare – women who discussed the kits emphasised their important role in providing essential items that are becoming increasingly out of reach, financially.

Figure 16: Satisfaction with Dignity Kits among Recipients of Safe Space Services



“Dignity kits play a valuable role in remaining healthy, as most families cannot afford to provide for the sanitary needs of women. We ask for the dignity kits to be provided regularly.”

– (FGD participant, Iraq)

“Most women and girls answered that the dignity kit is excellent. They said that it has contributed to their comfort and satisfaction. They can now carry out their activities and come to the centre to benefit from its various services confidently without worrying how to secure these supplies, especially due to their financial cost.”

– (FGD participant, Jordan)

“The economic situation is so bad, so I was ashamed to ask my parents. When the centre distributed them, I was happy and felt that I had relieved my parents of the burden a little.”

– (Adolescent FGD participant, Lebanon)

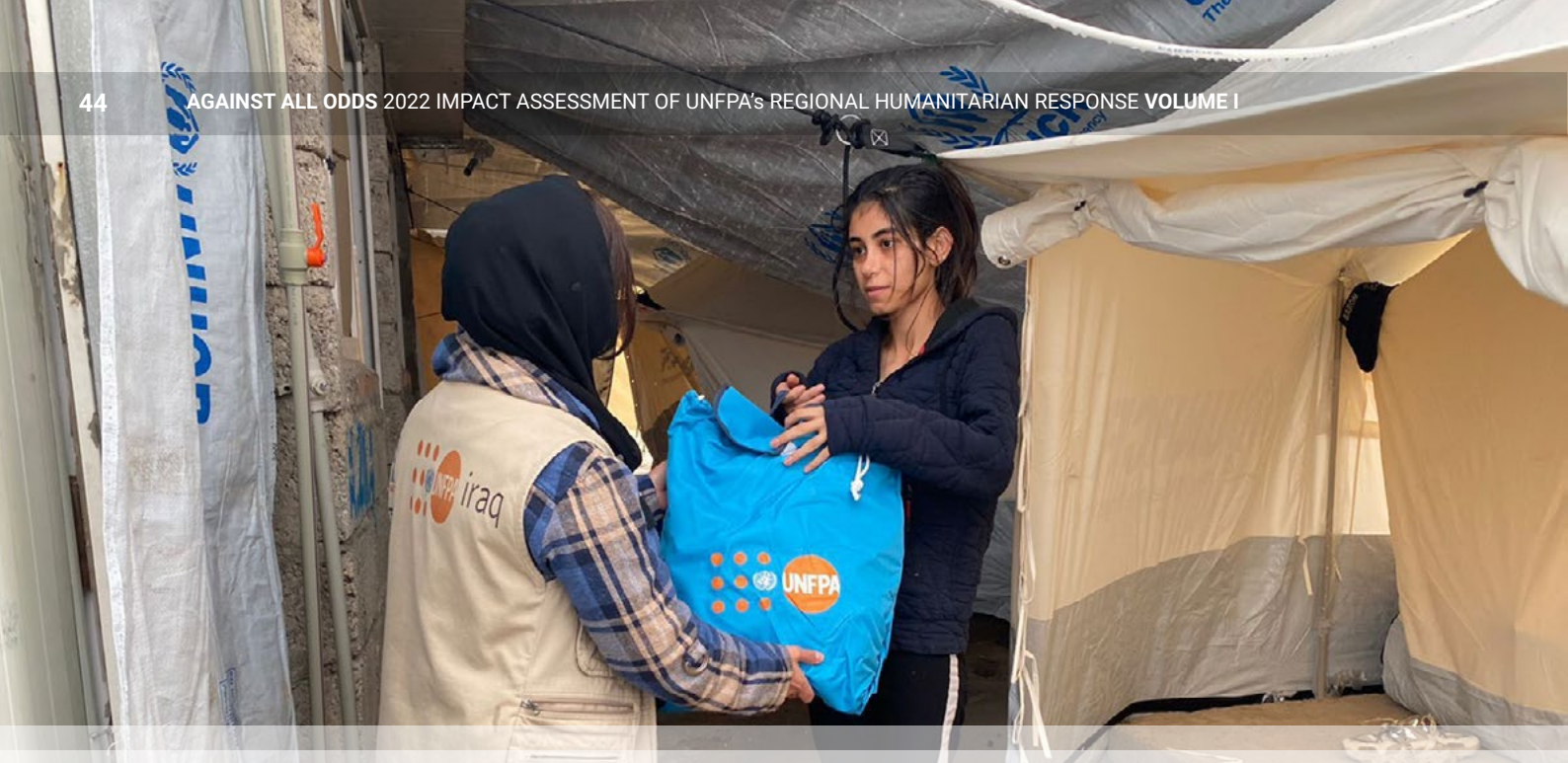
“Its contents allowed me to leave my house.”

– (FGD participant, Lebanon)

“Even my husband benefited from the flashlight that was provided in the kit. He goes out at night due to his job.”

– (FGD participant, Yemen)

In **Lebanon**, however, the distribution of dignity kits is coming with an unanticipated cost to programming – the demand for kits is so high as the economy deteriorates for Syrians that people are entirely focused on the receipt of the kits themselves rather than the SRHR services that accompany them.



“Yes, we need more kits and no, we don’t. Yes, because they are in massive demand - prices for all the products in the kit are insane right now so even people who are not of lower income want them. I say no because the reason why they come for services now is focused only on the kits. We used to provide reproductive health services and give the kit at the end, but now we realise that women are coming just for the kits and not for the service so they are taking the place of someone who is actually in need.”

– (Lebanon IP)

Women across all countries that reported receiving the kits noted how they have contributed to the maintenance of hygiene, public health, reproductive health and psychological comfort. Women in **Sudan** also even noted using the bags that the kits are provided in as containers for personal items or even as school bags for children and that it has dramatically helped with menstrual hygiene management.

“[The kits] helped us to move freely while we performed our household work. We felt energised rather than scared, worried, or ashamed. Previously,...having our period made us feel embarrassed, but when we use the dignity kits, we move about and practice our lives normally. We can go to classes, and some of us go farming and to the market.”

– (FGD Participants, Sudan)

Women in **Syria** highlighted attending awareness sessions on personal hygiene before the distributions and how this increased their hygiene awareness and improved hygiene practices.

“The dignity kit made me feel better because it is related to personal hygiene and it is appropriate for all women, and especially for girls that go to school.”

– (FGD participant, Syria)

The most substantive *dissatisfaction* articulated was with respect to the frequency of distributions, with women and girls across all countries requesting more, and more frequent, distributions. There was a definite preference for the larger, family-type, kits, which contain more items, including underwear for men and boys and which last for longer, aiming to cover the needs of all family members. Some recipients also noted a need to tailor the kits to provide specific items for vulnerable people, for example PWD.

“I received the kit a few times, and it is not enough for the family. It may be enough for a few days of single use. There is nothing in it for the disabled. For example, it could contain diapers for my disabled children or batteries for the hearing aid. I change the battery every four days – think how expensive that is. It could contain a toy or a reading set for the development of my children.”

– (FGD participant, Türkiye)

“When we receive these kits, we feel better because someone cares for us and supports us. We feel shy to ask our parents for these items. It mitigates financial burdens, and we hope that these kits will be distributed to beneficiaries every month within the centre so that everyone can benefit.”

– (FGD participant, Türkiye cross-border)

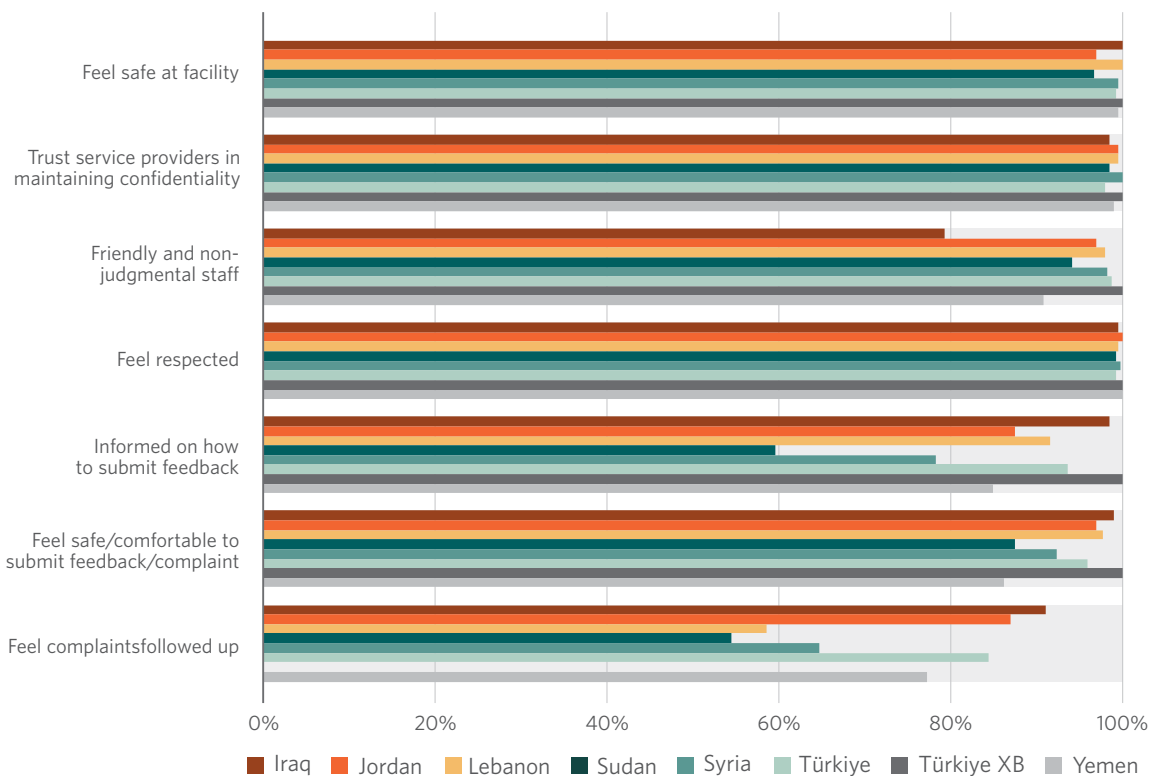
e. Feelings of safety and respect in services and providers and feedback mechanisms.

In Safe Spaces supported by UNFPA, there is a strong sense of safety and trust amongst the women and girls that attend, with no significant differences across age groups or by vulnerability status. This underscores the sentiments expressed above as to the success of Safe Spaces and centres in being a refuge for women and girls.

The chart, right, compiles responses to questions amongst attendees on their perceptions of safety, trust, respect with the facilities and the staff that run them. It also explores women’s and girls’ perceptions of their ability to submit feedback to the centres and whether this is responded to.

Figure 17: Feelings of safety, trust etc. in GBV SDPs by Country

Feelings of safety, trust, confidence and respect when accessing services at Safe Spaces (n=3048)



THE DIGNITY KIT MADE ME FEEL BETTER BECAUSE IT IS RELATED TO PERSONAL HYGIENE AND IT IS APPROPRIATE FOR ALL WOMEN, AND ESPECIALLY FOR GIRLS THAT GO TO SCHOOL.

– (FGD PARTICIPANT, SYRIA)



IF I BOUND MY EYES AND LET THEM GUIDE ME BY HAND, I WOULD WALK COMFORTABLY AND SAFELY.

It is clear that there is an overwhelming sense of trust and confidence in the centres almost across the range of country operations. As a service users in **Jordan** and **Lebanon** noted:

“If I bound my eyes and let them guide me by hand, I would walk comfortably and safely.”

“I feel I am visiting my mother’s home when reaching the safe space. I feel respected and welcomed here. I arrive holding all my pain and leave much happier.”

– (FGD participants, Lebanon)

Women and girls in **Iraq** highlighted how they feel comfortable and safe with no one to bother them. Staff are always working to serve them, always listening to the women and working towards their comfort. Responses from women and girls in other countries reflect similar perceptions:

“Women feel safe in this space because they can speak without fear, share their opinion and exchange their experiences with each other.”

– (FGD participant, Lebanon)

“They care about our decisions. After each meeting, they ask what we think. They don’t interrupt when we talk. They show respect. We can talk to the psychologist in full confidentiality.”

– (FGD participant, Türkiye)

“Safety for us is to enjoy privacy, without any harassment from men. Sometimes one of us sits down and her veil slips down and her head is uncovered but we do not feel embarrassed because we are all women. Safety for us is that soldiers can’t enter here. We are protected from those in our community who think that women who come here are not respectable. They want to beat us just to make fun of us.”

– (FGD participant, Sudan)

A key feature of the Safe Spaces supported by UNFPA is that they are for women and girls only, which provides an additional layer of confidence and increased sense of safety. In some cases (e.g. **Iraq**), women noted that this privacy is what helped parents and husbands agree to the participation of the women and girls in their households in the centres’ services.

“I feel safe in this centre. Here, I feel more safe than my house because when my father goes to work and my mother goes to the market and I am alone I am afraid of anyone who comes and knocks on the door, so I am always scared. The centre has guards preventing anyone from entering, other than women. There is transportation to drive us from the house to the centre. It is very safe because if we went on foot our parents would prevent us, fearing kidnapping. In addition to safety, we are free to express our opinions and talk, because everything is confidential in the centre.”

– (FGD participant, Türkiye cross-border)

“Yes, I feel respected. I felt hesitant to come to the centre at first due to my disability, but after I came and experienced the respectful treatment, I changed my mind. When I talk they listen to me with interest and respect, so my mental wellbeing is improving.”



– (FGD participant, Türkiye cross-border)

Provision of, and response to, feedback, while still positive, did not score as highly for respondents to the assessment surveys, in line with the findings of the 2021 assessment. While all countries have various mechanisms for soliciting feedback from women and girls attending the services (e.g. complaints/suggestions boxes reported in **Iraq, Jordan**), respondents in some countries (e.g. **Sudan**) reported being less informed on how to provide feedback, and some respondents (primarily **Sudan** and **Syria**) felt feedback was less likely to be followed up on.

For example, in **Jordan**, attendees at an FGD noted that complaints and observations were not being followed-up and there was no credibility in verifying or even following up their complaints, observations and proposals within the complaints box.

“Sometimes they listen to us, other times they don’t.”

– (FGD participant, Jordan)

This said, many women and girls provided good examples of feedback and requests being successfully responded to:

“Yes, we were listened to when we proposed to hold an exhibition. Now, we are organising this event.”

– (FGD participant, Sudan)

“My grandchildren needed tutoring courses for the 9th grade, and because I was unable to pay the courses’ costs, I spoke with the case management and they helped me and directed me to another centre, where my granddaughters were taught.”

– (FGD participant, Syria)

“When I went to other centres to learn sewing they refused to enrol me due to my age. Eventually someone told me about this centre and I explained my situation to them. I knew that they accepted women over the age of 60, and I graduated from the course with a good grade.”

– (FGD participant, Syria)

“I don’t feel very safe outside, but I feel safe in the centre. I like their communication style. They speak kindly and they try to solve all my needs.”

– (FGD participant, Türkiye)

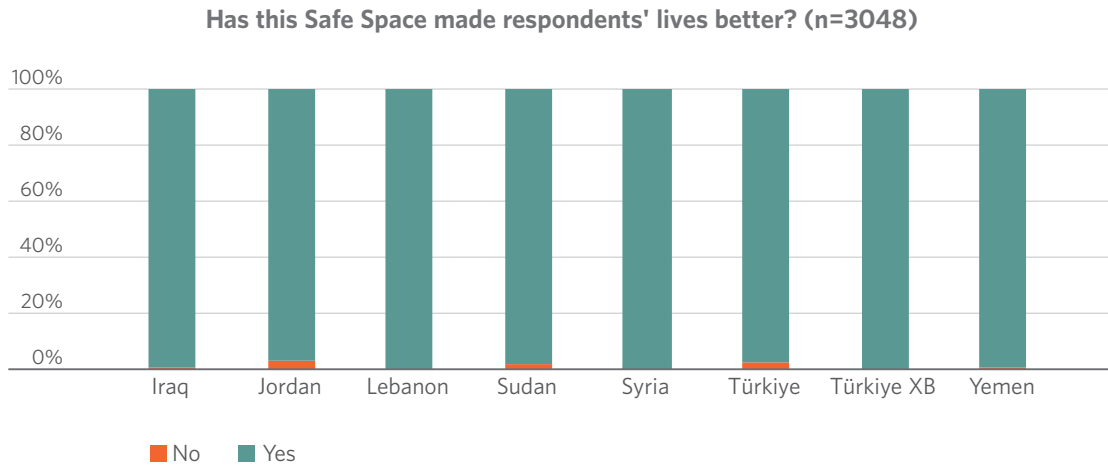
f. Contributions of services to the UNFPA mandate area of GBV.

A fundamental measure of the impact of services is their outcomes on the lives of those that benefit from them. In the case of the Safe Spaces supported by UNFPA across the humanitarian operations in the region, there was an overwhelmingly positive response with respect to the impact of the centres on women’s lives.

The chart, right, highlights the perceptions of over 3,000 women and girls across the eight humanitarian operations as to whether the centre has made their lives better. As can be seen, respondents almost unanimously agreed that it did, with less than 1% overall feeling that it did not.

In **Iraq**, women said that the centres they attended are safe for girls and women, are places where they can get to know new people, learn new skills through courses, gain self-confidence and reduce the psychosocial stress they suffer from.

Figure 18: Perceptions of Life Improvement in GBV SDPs by Country



While there is little quantitative data related to the incidence of GBV (and such data is not reliable as incidence of GBV is dependent on a complex interplay of factors), there is considerable anecdotal qualitative data from the participants in this assessment as to the changes they are starting to see in their lives through the improved awareness of GBV, the support they receive from the Safe Spaces and the resulting positive outcomes on their lives. Examples of such accounts are as follows:

“I was engaged to be married. After joining the centre and participating in awareness-raising sessions on the social effects of early marriage and those related to sexual and reproductive health among adolescent girls, I made my decision to break off my engagement. Today, I am a girl who is learning and aspiring for a better life”.

– (FGD participant, Jordan)

“We recognised that we have become more social and productive, and we created a small fund that helps every person who needs capital to start her small project. We became more educated.”

– (FGD participant, Sudan)

“Case management made a new person out of me after I experienced violence. Then the hairdressing course helped me start my own business, which has become very popular.”

– (FGD participant, Syria)

"My psychological condition was very bad. I was thirteen years old when my father married me off without my knowledge. My father's debts accumulated and he was unable to pay, so he married me in exchange for the debt. I lived with this man only three days after which my brothers came and took me back. I was divorced at a young age. All of this affected me psychologically. I refused to talk to others or make contact with anyone. My mother took me to the doctor, but it didn't help. After a while my mother asked me to register here in the safe space and I met the psychologist. I felt more comfortable because here I can release all my positive or negative energies and I relax here more than anywhere. Now I attend every Thursday to receive the services and this has truly changed my life."

– (FGD participant, Yemen)

In **Iraq**, IPs noted how the activities implemented in Safe Spaces took time to become acceptable to the Syrian refugee community there, but now they can conduct awareness-raising activities on GBV with both women and men (via separate outreach activities), with GBV lessening over time. Partners emphasise the importance of vocational training that encourages women to launch their own businesses that contribute to family income which is leading to reductions in GBV.

"This awareness has filled the gap between the man and the woman, and has helped in initiating a more understanding environment, and made the woman aware of her rights."

– (Iraq implementing partner)



In many cases, women did not regard the verbal and the psychological abuse practiced against them as kinds of violence, but attendance at the centres supported by UNFPA has provided them with the knowledge that such violence is not acceptable. Partners in **Iraq** and **Jordan** report on how they couple awareness-raising and GBV case management activities with *Safety Plans* for survivors of GBV which they report are successful strategies for survivors to reduce the effects of violence and help them refer either to medical services or the law.

IPs in **Jordan** report on how awareness sessions have very good effects on women, girls (via the *Girls Shine* initiative) and even among the men that engaged in these sessions. They report increasing numbers of people rejecting the idea of early marriage and increased reporting among women of GBV, including in relation to cyber-bullying, after trainings on this issue.

In **Lebanon**, partners report many Syrians seeking to attend awareness sessions on GBV and women's rights. The people attending the sessions speak about how these sessions have changed their lives and are beginning to change gender norms, with reports of men beginning to help their wives in household duties if she is working.

"People attending the information sessions keep telling us that they have got to learn new things, and begun to know how to deal with the pressures of life. The impacts we see are not only on the level of GBV, but also on the social level. The beneficiaries have started to exchange these ideas, information and experiences with each other to find additional advantages; some women have even told us that their husbands have changed after the first session."

– (Lebanon Safe Space staff)



Also in **Lebanon**, partners report that cases of GBV have been increasing substantially due to the ongoing effects of the triple crisis of COVID-19, the 2020 Beirut Port explosion and the economic collapse. They see many more women who come looking for help, with the main limitation being the number of shelters available. A proposal for additional shelters in partnership with the Lebanese Ministry of Social Affairs and the National Commission For Lebanese Women in 2021/2022 has seen little progress, despite extensive advocacy by all partners. Nonetheless, existing services are seeing increases in people willing to talk about GBV, and hence numbers of women and girls receiving GBV services. In 2021, GBV services were linked to both cash assistance and SRH services which have proven very popular across the country, with the CO noting an increase in people willing to discuss GBV as a result.

In **Sudan**, UNFPA's support to awareness-raising and services on GBV in a high-conflict environment are reported by service providers to be bearing fruit – partners are increasingly knowledgeable about referral pathways, people are becoming familiar with how to report GBV, how to seek medical assistance in case of rape or sexual harassment and how to take advantage of legal services. Women's Centres hold coffee morning sessions at which discussion sessions enable women to know more about GBV including domestic violence. Outreach with men in the Darfur region is reported to be having positive results on changing a "masculine mentality" widespread in Darfur. Partners also report a continuous increase in service uptake – demonstrating increasing awareness of GBV issues.

UNFPA in **Sudan** reported that challenges with the GBV context in previous years – lots of turnover of care providers for CMR and challenges in the supply of RH kits – have eased. UNFPA has worked in 2021/2022 to update data structures, map CMR networks nationwide, smooth coordination with HIV actors to bridge gaps in areas without CMR supplies and unify the community support structures between SRH and GBV, Preventing Sexual Exploitation and Abuse (PSEA), promotion of safe motherhood etc.

Syria also reports increases in demand for GBV services, with increasing numbers of women survivors of violence coming to facilities (often with friends and neighbours, and even sometimes with the violence perpetrator) to seek case management. In 2021, UNFPA piloted a mobile team that integrated GBV and SRH services. A positive evaluation of that pilot led to development of standard operating procedures (SOPs) and scale-up of the service to 24 mobile teams. Further, Syrian partners have established community committees for both women and men that engage in awareness-raising and advocacy campaigns for GBV and also for SRH and general health issues.

"We organise awareness sessions on GBV. At the beginning, there were some difficulties, then we noticed that women started to accept the ideas. Now, we see changes and more interaction. For instance, I put forward the issue of inheritance for discussion and have noticed positive changes in social traditions. We have introduced women to their rights, given them new skills on how to deal with their husband and family, how to protect themselves from violence, and how to gain self-confidence and cope positively with problems."

– (Syria Safe Space staff)

"When areas in East Aleppo that were under ISIS control for several years became accessible, UNFPA opened a Safe Space – initially the community was reluctant to send women and girls to the centre as they felt it was promoting "Western" concepts. Partners conducted outreach to raise awareness and provide important information. The Safe Space became accepted and has even trained women to drive cars, which would have been prohibited under ISIS. They earned their driving licences and from this some got jobs as drivers. The community went from being completely radicalised to quite openly accepting of women working and driving. The lesson is that it is important to have patience and work on gender transformative interventions."

– (Syria CO staff)

In **Türkiye**, partners report increases in awareness of GBV and rights that are resulting in women becoming more aware of GBV and its causes and to seek redress, for example, via claiming their rights under the civil law to alimony, property etc., or to protect themselves from violence by issuing restraining orders against their spouses or partners who inflict violence upon them. Partners also report considerable anecdotal information regarding parents deciding not to marry off children due to information sessions supported by UNFPA.

"This is the centre where I can breathe," said one woman. "There is racism and discrimination in Türkiye, but the Women and Health Counselling Centres offer a safe and secure environment where they are tolerated and their issues can be left behind."

– (Türkiye IP)

After seven years of transformative interventions, **Türkiye cross-border** programming is also recording shifts in deeply rooted and unequal social norms and practices, notably through its ongoing awareness-raising efforts conducted at the community level. By using the GBV Sub-Cluster-developed awareness-raising toolkit in its outreach efforts – which provides four comprehensive programs for raising awareness around seven key GBV messages to women, adolescent girls, men, and adolescent boys – UNFPA and its IPs have gradually promoted behaviour changes in targeted communities as well as the emergence of new ways of thinking. Additionally, UNFPA's IPs have noted that GBV programming is positively impacting psychological wellbeing of targeted women and girls, providing a safe space to release stress and pressure. They also highlighted the benefits of vocational trainings on women as they become able to play a vital role in the daily lives of their families and community. In particular, the location of the women's centres within communities is reported to improve the overall sense of social cohesion within these communities. Partners report that 75% of cases referred to case management come from awareness sessions, with the effectiveness of these sessions demonstrated by survivors that stated that the violence against them is decreasing day-by-day after attending these sessions.

In **Yemen** partners also reiterate the value of vocational training in enabling GBV survivors to earn an income and support their families and children. This maintains economic stability for the GBV survivor as many cannot escape due to financial dependence. UNFPA also reported leveraging its mandate and profile in their work on female genital mutilation (FGM) among women and girls which has started to have an impact, although it is still a highly sensitive topic and cannot yet be quantified. UNFPA also noted success in 2022 on awareness-raising of the humanitarian community in mainstreaming GBV within programming. The CO reports constant requests for technical support in women's engagement and promotion of gender equality. Thus, it is bringing attention to GBV among humanitarian leadership and providing encouragement to women-led organisations locally. Work on CMR is also ongoing, although substantial stigma around it generates challenges in acknowledging rape, application of the CMR protocol and use of post-rape kits. Hence the work they do on GBV is fundamentally restricted.

Despite the evidence of successes in changing norms and empowering women (and men) to address GBV, there are other challenges that UNFPA and partners face.

In **Lebanon**, participants explained how the stigma around GBV means they need to come secretly to Safe Spaces because their husbands don't allow them to come. One woman noted: *"it is the one private thing I have in my life, and I will do anything to protect it."* (Lebanon)



In Iraq, the lack of facilities to take care of GBV survivors is a major constraint. Partners are clear that it is not even necessary to prove that there is a need – it is self-evident and the impact is immediate from the uptake. They report difficulties to talk about the prevalence of GBV in the Kurdistan Region of Iraq (KRI) due to stigma, although they recognise an increasing willingness to report cases.

In **Jordan**, partners recognise that GBV has shown lasting increases as a result of COVID-19. They look at access to services – more women are seeking and accessing services in **Jordan** over the past year. They acknowledge changes at individual levels, but not at large scale. UNFPA and partners are still dealing with entrenched cultural issues. While services are extremely important to survivors, they deal largely with the symptoms. When women are provided awareness raising and empowerment, they come up against cultural issues which will take a long time to change.

“Women feel afraid of going to an unsafe place, telling her story and facing judgment. We still live in a community where the woman’s complaint

against her family and husband is not welcomed.”

– (Jordan Safe Space staff)

In **Sudan** UNFPA experts feel GBV is still increasing due to the ongoing crises, revealed by increased demand at UNFPA-supported safe houses for survivors in Khartoum. This is exacerbated by stigma around GBV which leads to underreporting and increased vulnerability. UNFPA also reports fears of reporting due to many perpetrators being members of armed forces. The UNFPA publication *Voices of Sudan*, first published in Sudan in 2021, shone a light on the women and girls that face GBV. However, the ongoing crisis related to the military takeover in 2021 has delayed the 2022 publication of *Voices*.

In Türkiye, partners report that some of the least demanded services among Syrians are for GBV due to entrenched norms and unwillingness to report. There are challenges in accessing justice due to mistrust of the system and lack of enforcement of legal measures such as restraining orders.

“Yesterday, a 16-year-old girl was killed by her husband. She had gone to the authorities 35 times saying she was in danger from her husband. He will not be tried.”

– (Türkiye IP)



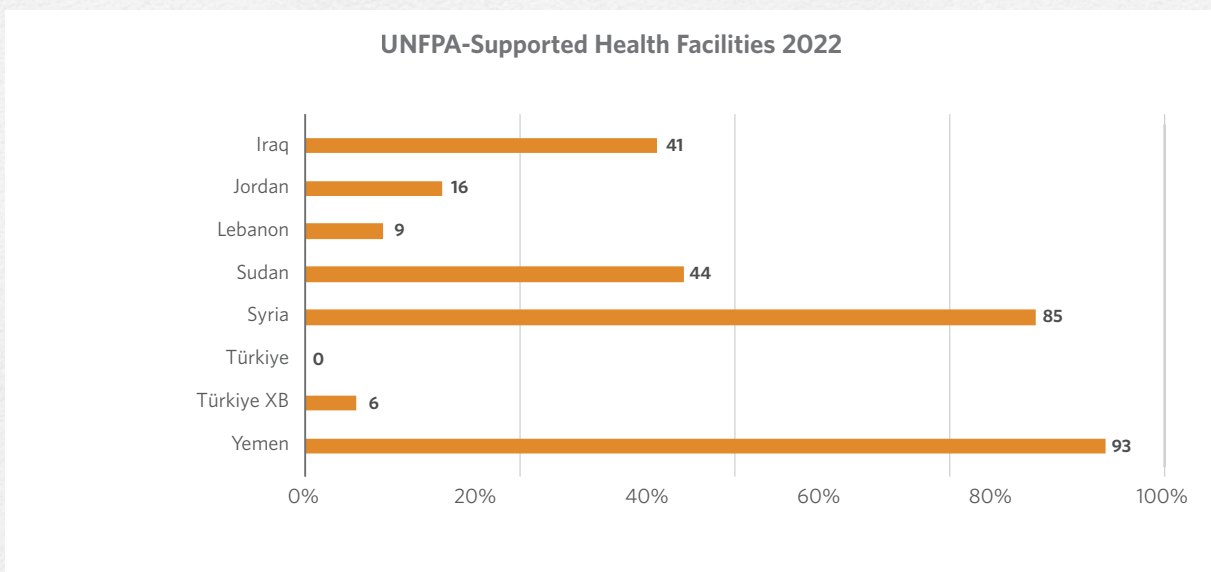
WOMEN FEEL AFRAID OF GOING TO AN UNSAFE PLACE, TELLING HER STORY AND FACING JUDGMENT. WE STILL LIVE IN A COMMUNITY WHERE THE WOMAN’S COMPLAINT AGAINST HER FAMILY AND HUSBAND IS NOT WELCOMED.

– (JORDAN SAFE SPACE STAFF)

Sexual and Reproductive Health & Rights

As of mid-2022, UNFPA was directly supporting 296 health facilities across the eight humanitarian responses covered by this assessment. These facilities include fixed health facilities (health posts, health centres, hospitals) and mobile clinics. In some countries, this represents a decrease since 2021 due to the transition of support to government control (e.g. Women and Health Counselling Centres (WHCCs) in Türkiye – although SRHR counselling is provided in integrated facilities that receive ongoing support in this country) or to longer-term development programming modalities (e.g. Iraq).

Figure 19: UNFPA-Supported Health Facilities by Country 2022



a. The range of services/activities provided at UNFPA-supported facilities.

As UNFPA generally works through, and in partnership with, national health systems to support the provision of needs and fill gaps in services, there is a wide range of engagement across the different response countries. For example, in **Iraq**, UNFPA works with the Ministries of Health in both Baghdad and in the KRI to provide a range of health services related to its mandate.

In **Jordan**, UNFPA continues to be the only provider of SRH care within camp settings. The services cover family planning, pre-pregnancy care, prenatal care, pre-marriage counselling, PNC, post-abortion care and include home visits for beneficiaries who can't visit the centre.

In **Lebanon**, UNFPA must negotiate the impacts of a crippling economic crisis that the country has faced since 2019. It has had severe impacts on the quality of health care available to the public, with 40% of doctors and 8% of midwives and nurses having left the country and increasing costs of healthcare and transportation making it more and more difficult for the Syrian population to access care. UNFPA works with institutions to streamline recruitment and develop the capacity of the remaining workforce, improve access to medications, and is developing good practice guidelines on pregnancy nutrition and mental health – the latter being the first of its kind in the region.

In **Sudan**, crumbling health infrastructure and disruptions in health system governance caused by the 2021 military takeover (and resulting replacement of a substantial proportion of the civil service) means that UNFPA provides a very wide range of support (in coordination with the Ministry of Health & Social Development) across the full spectrum of SRHR needs, in line with Minimum Initial Service Package (MISP) and emergency response guidelines. This includes training, staff support, medical supplies/equipment, procedures and awareness raising amongst the community across transit centres and refugee/IDP camps across the south, including in Darfur.

On-the-Wheels Clinics, Sudan

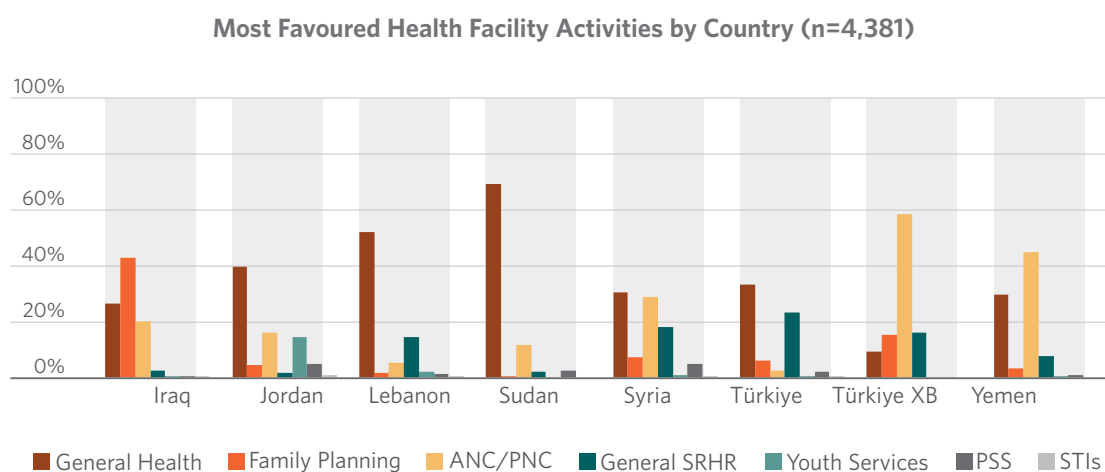
In Sudan, UNFPA has seen good success in its support to deployment of “on-the-wheel” (o-t-w) mobile clinics that can quickly be deployed using vehicles and tents in areas of health needs. The clinics are equipped with a variety of diagnostic and treatment facilities (e.g. ultrasound) and can provide a wide variety of services. To date, UNFPA Sudan has procured 3 o-t-w clinics that are providing MISP services and are seeing observed reductions in mortality and morbidity amongst women that previously had little or no access to SRHR services.

Through **Türkiye cross-border** operations in north-west Syria (NWS), UNFPA supports through its IPs the provision of a wide range of integrated SRH-GBV services, including family planning methods, antenatal care (ANC), PNC, infection treatment, delivery services, clinical management of rape and lab services. In 2022, **Türkiye Cross-border's** IPs expanded their SRH services for advanced cancer screening, both through mammography and Papanicolaou (Pap) smear procedures, HIV testing, and nutrition. A mapping of available breast cancer services was developed and referral pathways were activated inside and outside NWS. The cross-border referral mechanism between NWS and Türkiye has proven to be effective to provide comprehensive and quality care to early-detected cases of cancer, increasing the chances of positive outcomes of the medical treatment.

In Türkiye, the SDPs that are integrated in the Migrant Health Centres (MHCs), including some Safe Spaces, provide SRHR counselling and services at primary health level. The centres that are not integrated to the Ministry of Health (MOH) refer beneficiaries to affiliated MHC that are supplied by UNFPA with family planning (FP) commodities.

Analysis of health needs articulated by attendees at health facilities across the region is presented in the chart below. It shows that there is a high demand for general health needs within the facilities (or, at least, health needs not covered by UNFPA's SRHR mandate, such as chronic illness treatment, diagnostics, medications or surgery). Aside from this category, ANC/PNC, family planning and general SRHR are highly popular services in these facilities.

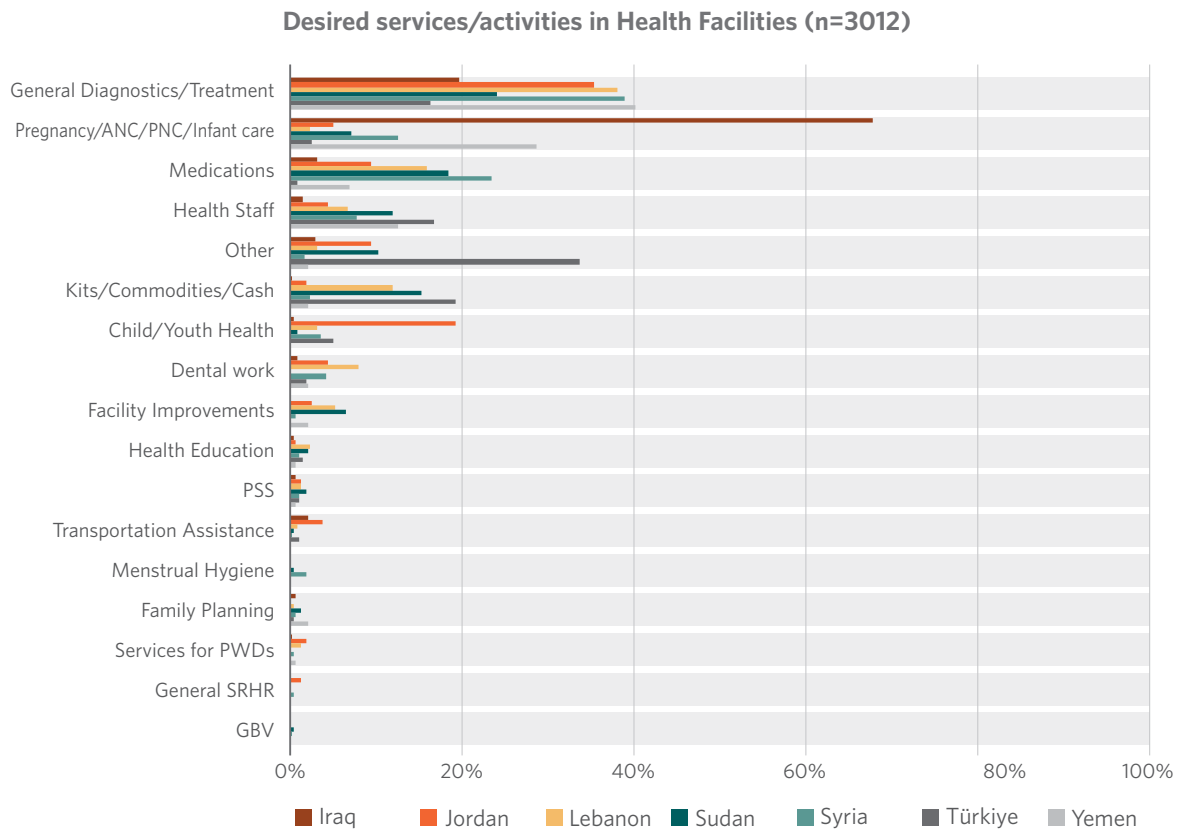
Figure 20: Most Favoured Health Facility Activities by Country



b. Any desired changes or additions to services.

Similar to the overall favoured services described above, most women that participated in this assessment noted that their greatest unmet health needs were related to general health services outside of UNFPA's mandate areas – reflecting the limited nature of much of the healthcare in the countries where UNFPA works. Women expressed desire for a very wide range of services such as general examinations, in-patient services, improved facilities, surgeries and treatment for a wide range of chronic and acute illnesses, not currently available at these centres.

Figure 21: Desired Health Facility Activities by Country



With respect to UNFPA’s mandate areas, however, there was a clear preference for increased work in the areas related to pregnancy – ANC, PNC, infant care – and particularly in Syria. This was followed by a desire for medications – which are either in short supply in the participating countries (due to pipeline/logistics issues) or are too expensive for patients to afford to pay from their own pockets.

Availability of health staff was another key constraint, which is in line with the challenges (in recruitment and retention of health specialists) noted by many IPs in response countries.

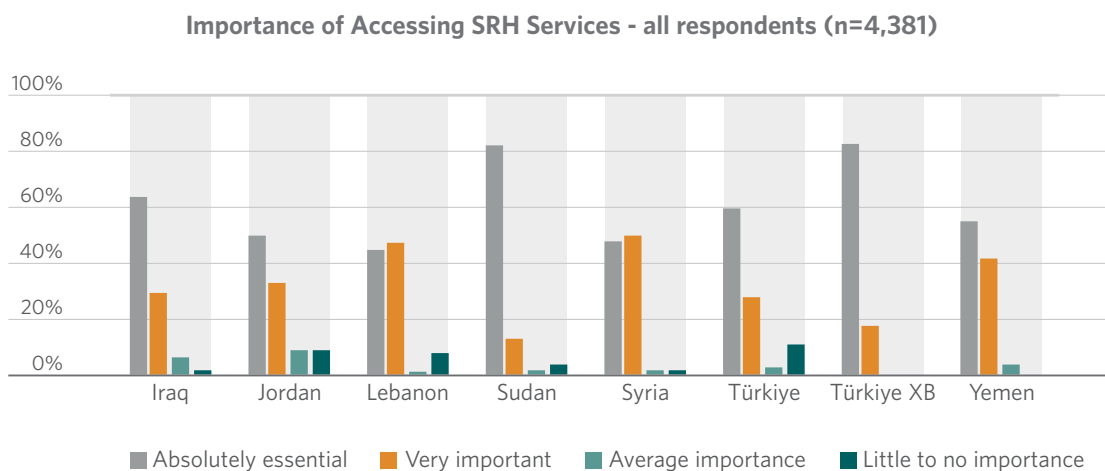
c. Importance of and reasons for attending services.

Similar to other facilities supported by UNFPA, women attending health facilities almost universally considered the SRH services offered by them to be either absolutely essential (average of 61% of respondents per country) or very important (average of 32%). The numbers of respondents that felt SRH were of little or no importance were all less than 10%, except for **Türkiye** (at 10%). The reasons why women may not have considered these services important were not explored by the survey.

This year, we did not record any maternal mortality at our centre due to being able to offer complete medical services and integrated care services which are not available even in any other private hospital – and all our services are free.

(Health Facility Staff, Idlib, Syria, cross-border programming)

Figure 22: Importance of Accessing SRH Services by Country



d. Feelings of safety and respect in services and providers and feedback mechanisms.

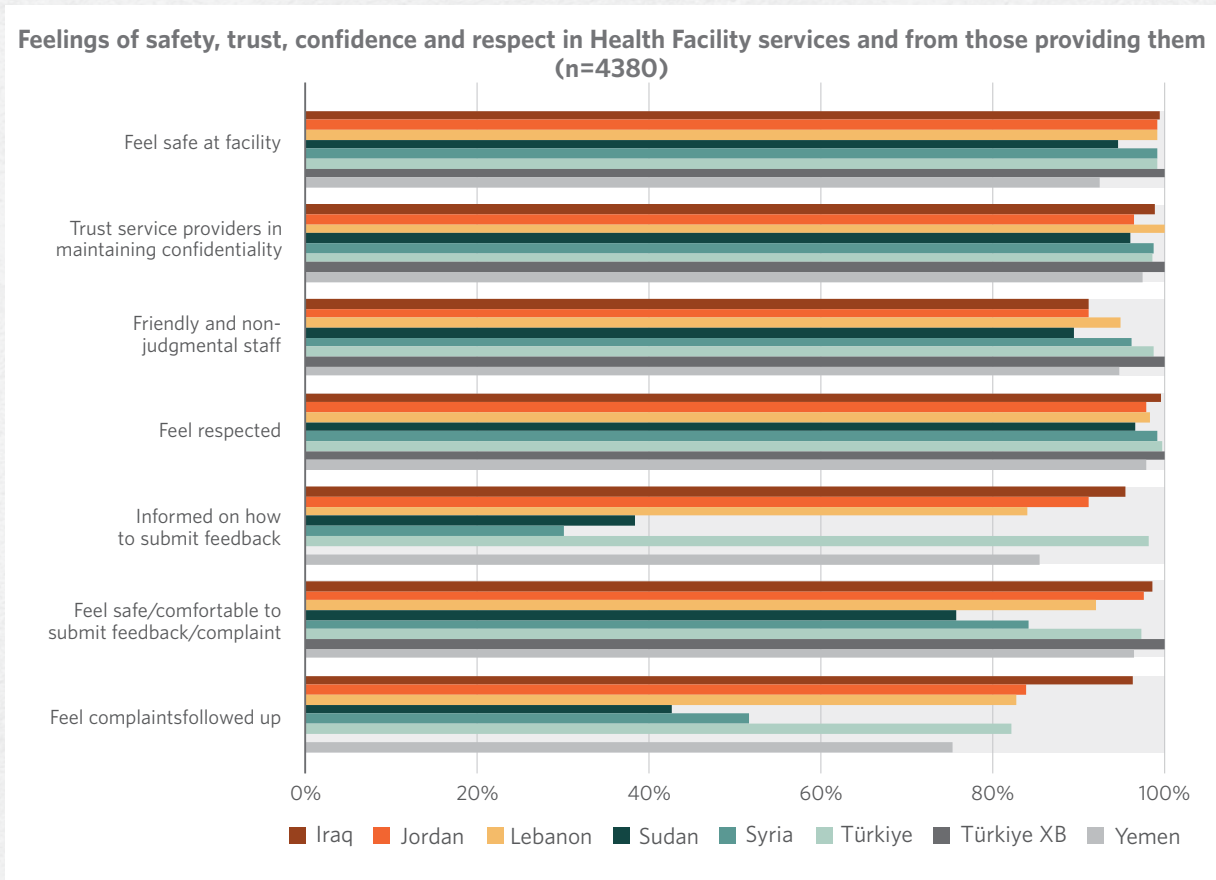
The overwhelming majority (>90%) of women attending health facilities expressed that they felt safe, trusted the staff and felt respected, as shown in the chart below. This was consistent across all countries for all areas related to trust, confidentiality, safety and respect.

As with other types of service providers, performance was less well-rated for feedback and accountability mechanisms.

While women from some countries (notably **Iraq, Jordan, Türkiye** and **Türkiye cross-border**) rated their health facilities highly on provision of feedback mechanisms, others (**Sudan** and **Syria**) were less pleased with the mechanisms and their perceptions of responsiveness to feedback. Their responses suggest areas for future emphasis by UNFPA to better meet its commitments to AAP (as part of the Grand Bargain, which was relaunched in 2021).



Figure 23: Feelings of Safety, Trust etc. in Health Facilities by Country



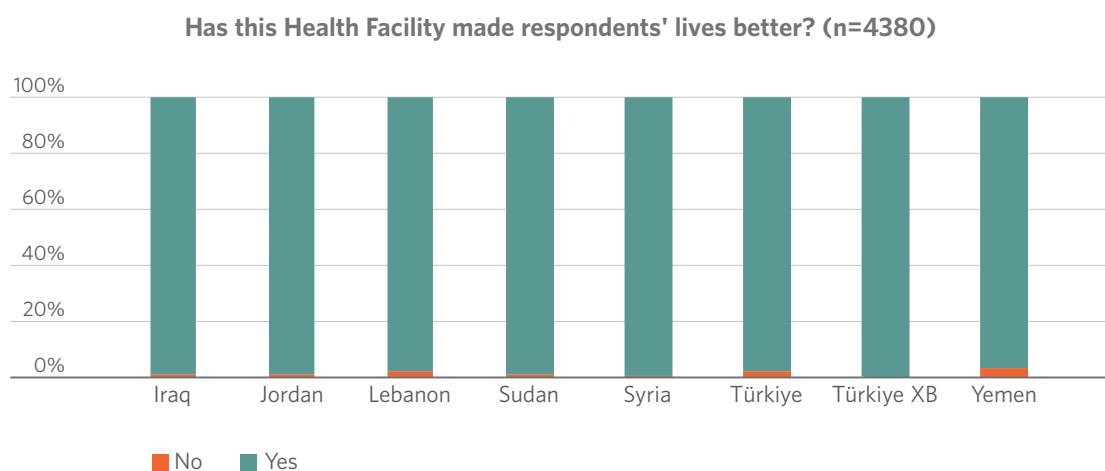
e. Contributions of services to the UNFPA mandate area of SRHR.

It is clear from responses by the more than 4,000 women surveyed regarding the health facilities supported by UNFPA that the services delivered there contribute positively to health outcomes in women’s lives. Across all countries, 98-100% of women agreed that the facility at which they were attending had made their lives better – a unanimous endorsement. There was no significant difference across age or vulnerability characteristics, except between PWDs and non-PWDs in **Yemen**, where 5% of PWDs felt the health facility hadn’t made their lives better, vs. 2% of non-PWDs.

Ips also noted how the quantity and quality of SRHR services offered by health facilities are directly impacted by the support of UNFPA. In **Iraq**, partners strongly felt that maternal mortality was being reduced due to this support and the increased availability of doctors and medications in supported facilities and the support to mobile health teams in refugee camps, as well as ensuring adequate ANC care for pregnant women. Further, in family planning, a new family planning strategy is in place, with UNFPA-supported training of staff on decision making tools for family planning services, meaning that such services can be provided even in the absence of a doctor.



Figure 24: Perceptions of Lives Improved by Health Facilities by Country



IFH, an IP in **Jordan**, highlighted how free-of-charge SRHR services have led to increased access to comprehensive SRH services (including ANC, PNC) services (in line with World Health Organisation (WHO) and the Jordanian MoH guidelines) by women, more follow-up visits related to pregnancy and family planning and improved referrals of at-risk patients, although they also noted a trend of reducing demand for family planning in Jordan. To combat this and also perceptions that SRH is “only for pregnant women”, UNFPA partners promote and implement couples counselling in supported clinics.

In **Lebanon**, partners highlighted transportation challenges faced by Syrian refugees in accessing health facilities caused by the economic crises. Even mobile clinics supported by UNFPA are unable to access all remote areas due to political and social constraints, particularly those that offer SRH services in conservative areas.

While most expert stakeholders attested (anecdotally) to reductions in maternal and infant mortality in the specific facilities where UNFPA works, this is against a backdrop of an overall increase in the context of COVID-19, which led to fewer women being able to access essential SRHR services.

“There was a sharp increase in maternal mortality in 2021 due to COVID-19 – from 15 deaths per 100,000 births to 45 – this is an issue that we’ve been trying to address in the last year.”

– (Lebanon CO staff)

Partners in **Jordan** noted improvements on timescales of four to five years, but such incremental changes are more difficult to see on shorter time scales. In **Türkiye**, UNFPA acknowledges challenges in determining impacts/outcomes, but reports a definite increase in demand for SRH and FP services. Anecdotally, at the provincial level, there seems to be reports of reductions in infant and maternal mortality.

Some countries note ongoing challenges of lack of awareness of healthy and health-seeking behaviours among pregnant women and new mothers. Health facility staff in **Lebanon** noted how many women still have limited awareness of the risks faced by pregnant women, and that they have been undertaking awareness sessions on health issues, the importance of the breast feeding, vaccinations (including for COVID-19) and health monitoring.

In **Sudan**, UNFPA support, particularly in RH kits, are hugely important in providing basic healthcare to women due to extremely high levels of poverty which mean most people cannot afford private healthcare. The maternal death surveillance system supported by UNFPA has seen maternal deaths decrease from 3,000 per 100k in 2010 to 165 in 2021. UNFPA has also supported roving teams to establish Emergency Obstetric And Newborn Care (EmONC) facilities across states with higher humanitarian needs and the development of old or non-functioning health facilities:

"Before, the operating theatre at Al Jeniena hospital had a big problem in that the roof of the room was very old and leaking. UNFPA helped us to ensure the theatre was fully functional. Now, essential procedures, including caesareans, are conducted in a suitable environment which also led to reduction of mortality. The theatre and delivery room are fully equipped now to avoid any complications after the operation or the delivery. UNFPA has supported us to do many things to let the hospital work properly and appropriately."

– (Sudan Health Facility staff)



A key area of work supported by UNFPA alone in **Sudan** is fistula repair. From 2013 to 2022 in South Darfur, UNFPA has supported 235 successful surgeries in this potentially life-saving operation.

In **Syria** UNFPA reports being the only option in terms of SRH for many women and girls – and as of September 2022, 116,250 pregnant and lactating women had been reached. 2021 and 2022 has seen increased capacity to reach women and girls in communities via mobile teams (particularly as COVID-19 diminished), and referrals and uptake of services have increased. The midwifery network and distribution of RH kits has led to decreased mortality and morbidity on the ground in Aleppo and a new pilot network was started in Deir ez-Zor in eastern Syria.

In **Türkiye**, MHCs and Extended MHCs (of which UNFPA supports one, in Sanilurfa) have a wide-ranging system of referrals and services that, according to facility staff, means *"pregnancy-related deaths are no longer encountered"*. This is in part due to a holistic approach to health and wellbeing (although they prioritise GBV and SRH) that covers all family members. This is not consistent across all facilities, with some (e.g. in Hatay, on the southwestern border with Syria) still seeing high levels of pregnancy-related mortality. According to facility staff: *"What has been done to reduce the mortalities is not effective, it is not enough"*

In **Türkiye cross-border** programming, health facility staff report that UNFPA support has led to:

"high quality services provided in the hospital, with many cases referred to the hospital by others because of the very good quality of our services."

– (Türkiye cross-border Health Facility staff)

To grow the quality of service provided in **Türkiye cross-border** programming, increased efforts have also been made to enhance SRH and GBV integration, particularly within health facilities. UNFPA, in partnership with the GBV Sub-Cluster (SC) and the SRH Technical Working Group (TWG), have launched a GBV and SRH Integration Initiative targeting more than 79 health facilities in NWS. Since medical staff is often the first – and sometimes the only – point of contact for survivors seeking assistance for GBV, this initiative has led to an increase in the number of beneficiaries receiving essential and lifesaving services. Through capacity building activities and on-the-job supervision targeting more than 1,200 health service providers, significant progress has been achieved in enhancing their knowledge on GBV principles. This has improved cross-sectoral referral pathways to help ensure that GBV risk mitigation measures are mainstreamed in targeted health facilities.

Partners in Idlib Governorate highlighted that, for 2022, it hadn't recorded any maternal mortality at their facilities due to the UNFPA-supported integrated care services, which are available free of charge to women and girls.

In **Yemen**, partners attested to pregnant women's increased access to health facilities and antenatal, delivery and PNC having reduced maternal and neonatal mortality. For example, Al Makha hospital in southwest Ta'iz, a remote area along Yemen's west coast, used to have at least one mortality (maternal or neonatal) every week, but when, with UNFPA support, the facility became a reference hospital, maternal and neonatal mortalities dropped to only one in the last three years, despite deteriorating security conditions. Further, a 2022 analysis of the impact of UNFPA-supported mobile teams suggests reductions in maternal mortality by 50% across five mobile teams reaching five health facilities each.

However, despite these reports of success, partners report that the number of health facilities currently supported by UNFPA are inadequate to cover the needs of the populations, particularly in countries hardest hit by conflict (**Syria, Sudan, Yemen**) or by economic crisis (**Lebanon**). While anecdotal evidence indicates positive impact on cases of maternal illness, i.e. mortality averted, these represent a "drop in the ocean" and are against a backdrop of overall poor health outcomes for women and girls. In many cases, UNFPA support is making things "less worse". For example, in Yemen, UNFPA partners had to cease support to one health facility due to lack of funding, with a woman reportedly dying at the doors of the closed facility as she could not access life-saving care.

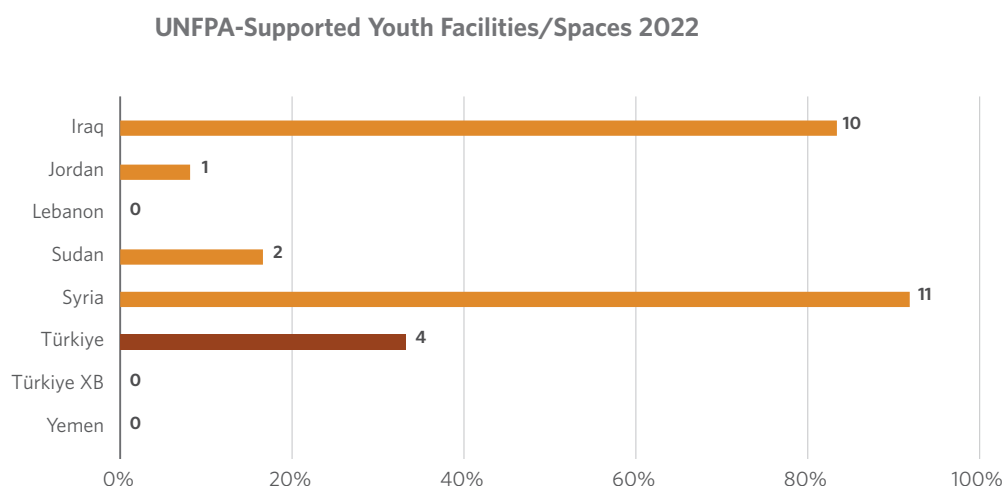
Youth Programming

a. The range of services/activities provided at UNFPA-supported facilities.

As of mid-2022, UNFPA was directly supporting 28 youth centres across the eight humanitarian responses covered by this assessment. The centres are located in both camp and non-camp settings. In addition to the support directly to facilities, UNFPA also supports standalone programmes for youth e.g. Girls Shine (**Jordan, Syria**) and work via educational institutions and health facilities to reach youth (**Jordan**).

This represents an increase in the number of facilities supported since 2020/2021. In **Iraq**, the number of facilities reported to have support increased from four to 11 in 2022, and in **Syria** from nine to 11. The four youth facilities reported in **Türkiye** (in Ankara, Diyarbakır, Hatay and Izmir) are included in integrated Migrant Health and Community Centres and provide SRH, GBV, PSS as well as similar services to other youth centres. They are supported with donor funds that are not part of the regional programme, hence are not specifically reported on in this assessment.

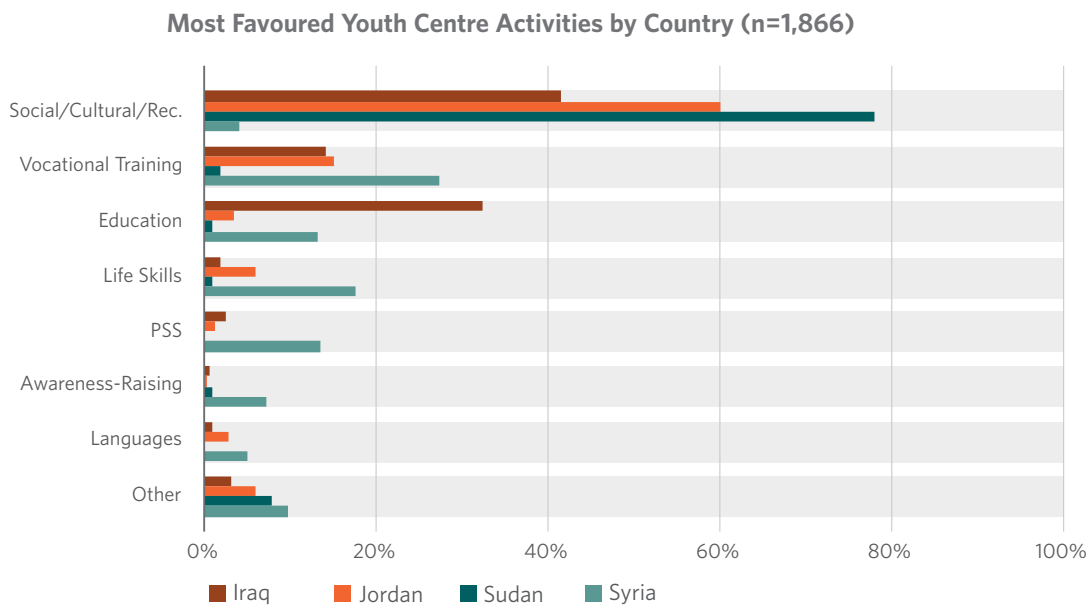
Figure 25: UNFPA-Supported Youth Facilities/Spaces by Country 2022



The most favoured and relevant services in youth centres reported by youth directly (presented in the chart, right), were those related to social, cultural and recreational activities. This was followed by vocational training, education and life skills.

There were some differences by country, with **Syrian** youth expressing an overall preference for vocational training, followed by life skills, education and then PSS. In **Sudan**, the overwhelming preference was for social/recreational activities.

Figure 26: Most Favoured Youth Centre Activities by Country



OUR CENTRE ACTIVITIES ARE VERY IMPORTANT, BECAUSE NO ONE ELSE CARES ABOUT PEOPLE WITH DISABILITIES OR IS CONCERNED ABOUT DEVELOPING SPECIALISED PROGRAMS FOR THEM.

— (FGD PARTICIPANT, IRAQ)



b. Any desired changes or additions to services.

Youth participating in the assessment were also asked about things that they would like to see in the youth centres that are not already available or that they wanted to have greater access to.

Most youth requested additional activities in the area of social/recreational – with most of those seeking additional physical activities such as sports, education and vocational training. The latter are a reflection of how, for many young people, the centres are one of their only opportunities to obtain additional training or skills after basic schooling is complete.

Figure 27: Desired Vocational Training services/activities in Youth Centres by Country

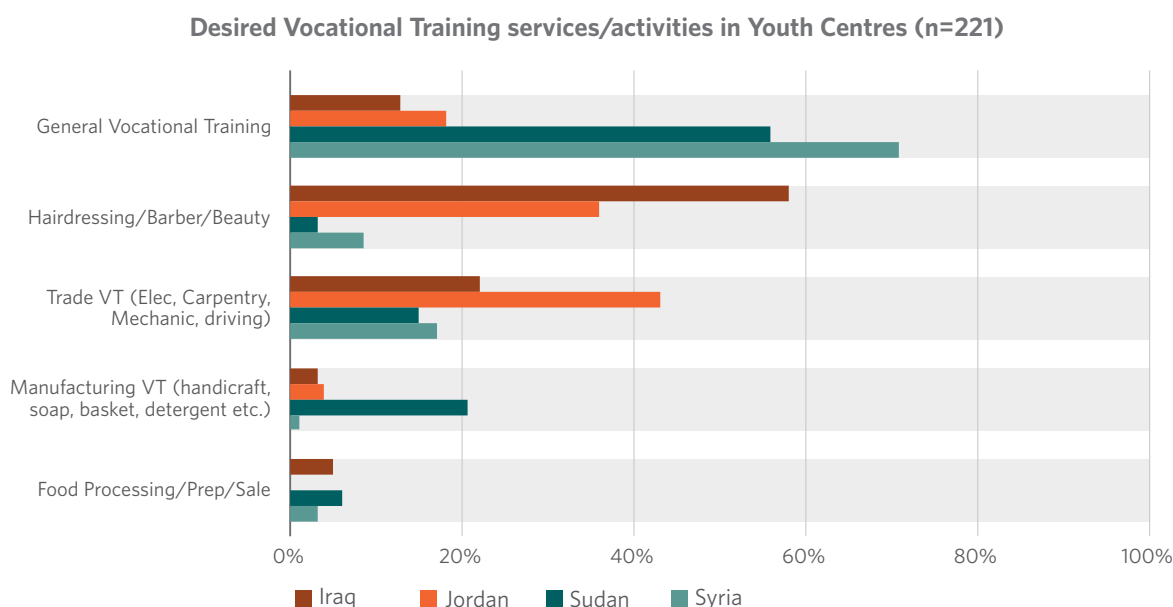
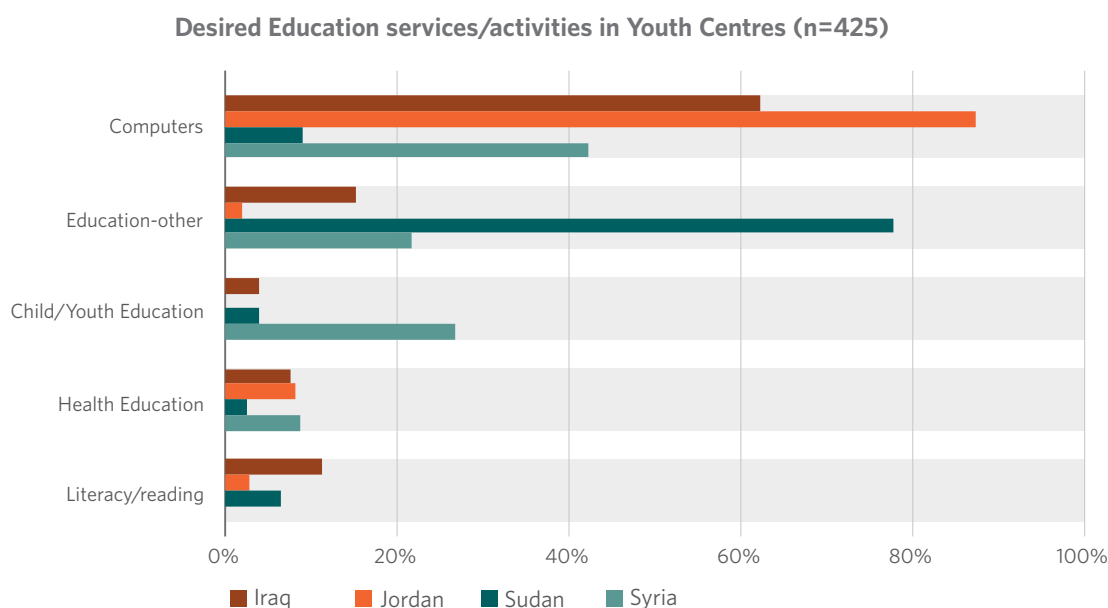


Figure 28: Desired Education services/activities in Youth Centres by Country



With respect to vocational training, while the sample size was small (only 14% of youth felt additional vocational training activities were needed), the most commonly chosen categories were around hairdressing/barbering/beauty, and trade-related work.

In education (see chart, right), the most common choice was in computers (except for in **Sudan**, where most young people opted for general educational services). Interestingly, provision of health education was a commonly-cited desire, with literacy and younger child/youth education (to primary level) also requested.

A common request not reflected in the survey of young people, but reflected in FGDs with groups of youth, was the desire to have the training and skills they received at the youth centres formally recognised via certification to assist them in security job opportunities. This is reflected in ongoing work in **Iraq**, where training at youth centres is accredited and certified by The Ministry of Labour & Social Affairs. This is a very useful initiative that links UNFPA's humanitarian work to longer-term sustainability of the work done via the youth centres.



c. Importance of and reasons for attending services.

Young people in the four countries with active centres for youth (in line with GBV and SRH services) were very positive about the importance of the services offered to them. Youth in **Sudan**, in particular, were very emphatic, with 83% of the respondents considering them to be essential. Less than 5% of respondents did not consider the services to be of at least average importance.

Feedback from discussions with young people at the centres highlighted some of the key reasons for attendance.

In **Iraq** and **Jordan** young people spoke about the importance of learning, sharing experiences, PSS/stress-relief, socialisation/recreation, “breaking the routine” and learning or skills-building, particularly for PWD (noted specifically in **Iraq**, where a high proportion (48%) of the youth centre attendees had a disability, compared to 23% of youth in the other countries).

In **Sudan**, youth also highlighted how the youth centres built their confidence, offered venues for neighbourhood meetings and allowed them to participate in the life of their communities.

In **Syria**, a greater focus was on self-development, increasing employability through vocational training and learning/study.

“We learn and practice skills, but honestly, I feel the centre is a source of happiness and inspiration. I like the people here because you feel that they are giving with love, and they are successful, and I wish to become like them and work with them”.

—(FGD participant, Syria)

“Our centre activities are very important, because no one else cares about people with disabilities or is concerned about developing specialised programs for them.”

— (FGD participant, Iraq)

“The outreach service is important to me as I learn about reproductive health and violence against women, and I gain knowledge about early marriage.”

— (Jordan)

Figure 29: Importance of Accessing Youth Services by Country

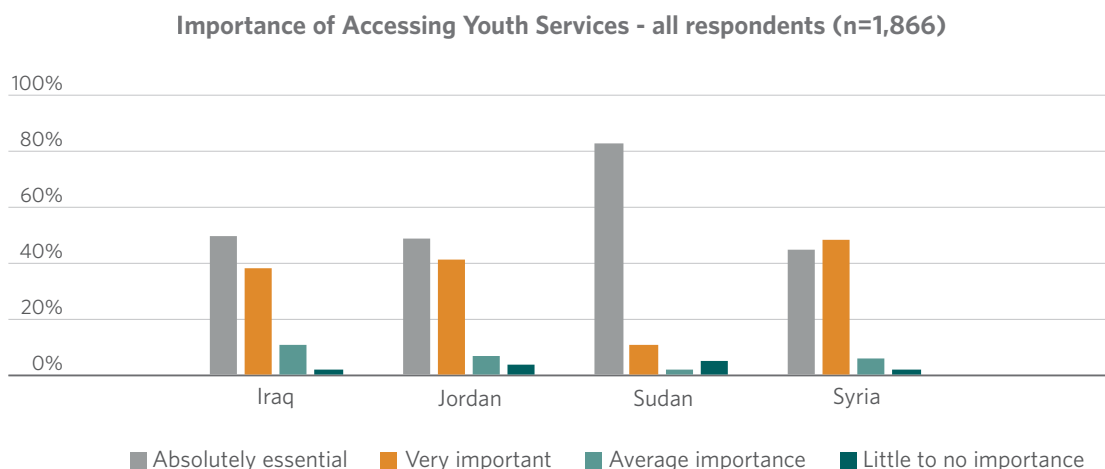
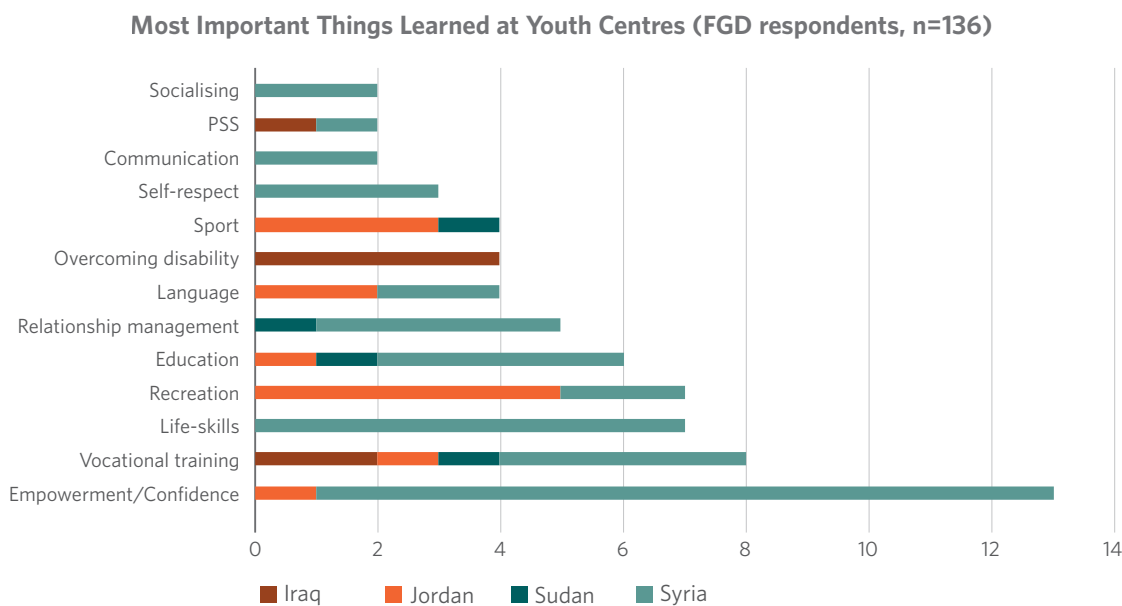


Figure 30: Most Important Things Learned at Youth Centres by Country



d. Feelings of safety and respect in services and providers and feedback mechanisms.

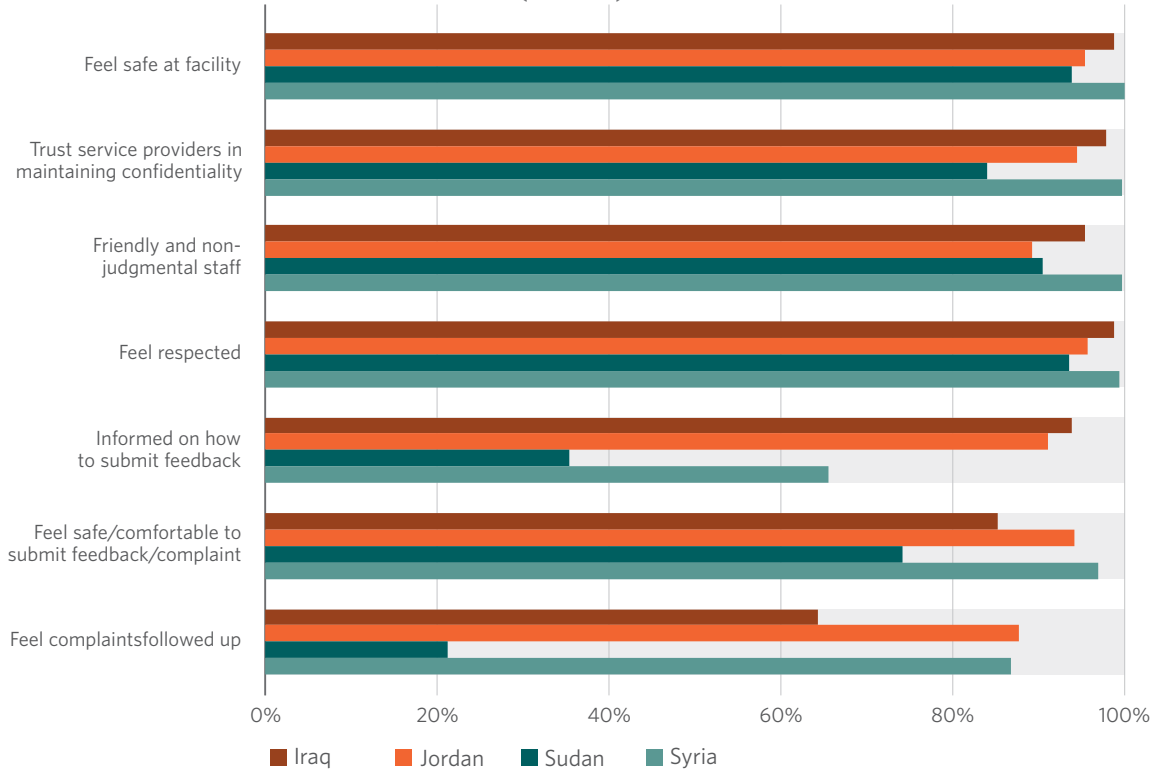
As with other UNFPA-supported facilities, young people expressed very high feelings of trust, safety, and respect across the four countries where youth centres are supported.

The chart, right, shows that 90% or more of young people responding (both male and female) in each country to the assessment survey felt they were safe, respected and served well by the staff.

Respondents in **Sudan** were slightly less positive about their experience, particularly in the area of feedback – both knowing how to submit feedback and in such feedback being followed up on (this may be a legacy of one of the supported youth facilities in Sudan being part of the a project which was taken over by UNFPA in 2021 after withdrawal of UNAMID from Sudan). This was echoed to a smaller extent in **Syria**.

Figure 31: Feelings of Safety, Trust etc in Youth Centres by Country

Feelings of safety, trust, confidence and respect in Youth Centre services and from those providing them (n=1866)



These findings correspond well with those from GBV and SRHR services, indicating that trust and confidence is very high, and a marker of quality services.

Yes, we feel safe, as do our parents, so they allow us to come to the centre. Safety to us means that we come and go without fear or being subjected to bullying and we can benefit from the services provided.

– (FGD participant, Iraq)

I feel safe, because many of the staff members are like brothers to me.

– (FGD participant, Jordan)

However, accountability to affected populations via feedback mechanisms is an area that could benefit from greater focus.

We feel disconnected from the managers at the centre and the gap is growing. They have never provided us any training, no direct questions, not even guidance.

– (FGD participant, Sudan)

It is important to recognise that some poor experiences of feedback are counterbalanced by positive experiences among other youth:

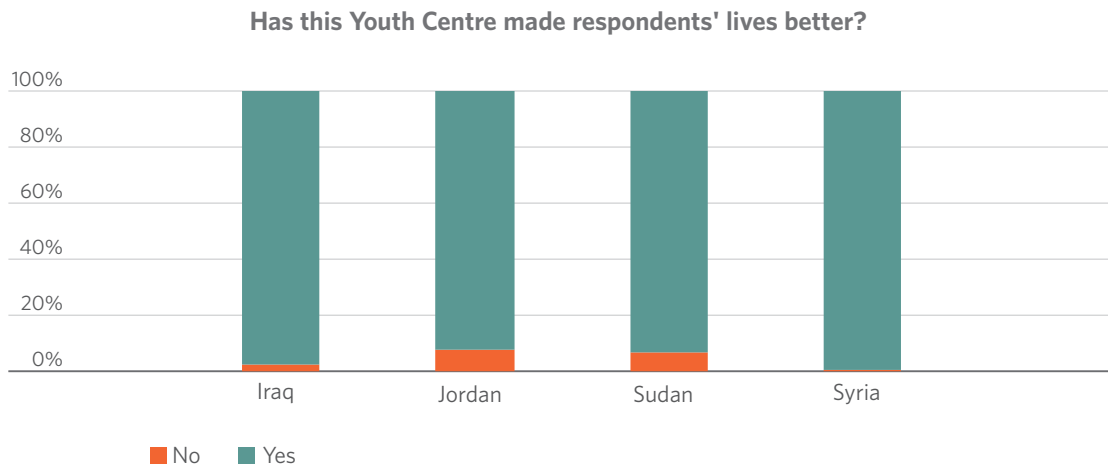
“It is very stressful at home, and given that I am in high school I was hesitant to ask the teachers here to allow me to study in the centre. But when I did, they actually helped me and created a study room for me.”

– (FGD participant, Syria)

e. Contributions of services to the UNFPA mandate areas of youth.

As with GBV and SRHR services, the perceptions of the substantial majority of young people attending youth centres in the four supported countries is that they are making their lives better. These findings are consistent for female and male respondents, though there was some slightly higher dissatisfaction among people with disabilities, particularly in **Jordan** (6% vs 12% PWD dissatisfied), suggesting that more could be done to make centres more inclusive (this is discussed further under Dimension B).

Figure 32: Perceptions of Life Improvements by Youth Centres, by Country



Testimony of young people from discussions highlights many personal changes that they have seen in their lives:

“I was on a path to failure and now I’m on a path to success. The centre helped me discover hobbies and sports and to do more with my time – and my life.”
 – (FGD participant, Jordan)

“The centre has expanded our knowledge and social networks. We can get to know each other more. The presence of girls and young men has broken the stereotypes in our lives and made us stronger people.”
 –(FGD participant, Syria)

IPs in **Iraq** highlighted joint work with the Ministry of Labour & Social Affairs in providing accreditation and certification to young people completing vocational training courses.

“If someone wants to open a hairdresser shop, he or she needs different [government] approvals, but trainees who have the recognised certificates don’t need any further approvals.”
 – (Iraq IP)

In **Jordan**, partners have linked awareness raising on GBV in camp-based youth centres as having positive effects, especially among the young men who engage in the sessions. They note many are now refusing the idea of early marriage, increased reporting of incidents related to GBV, including the relatively new phenomenon of online abuse.

Beyond youth centres, in **Jordan**, other initiatives link SRHR education to youth in second and third level education, meeting a substantial gap in knowledge of health issues via volunteer outreach and counselling sessions. Partners reported that for the last cycle in 2022, the target of 70 participants received over 800 applications. In 2021/2022, UNFPA supported preparation of a guide to youth SRHR awareness which was provided to 20 schools and, with the Jordanian MOE, piloted a comprehensive sexuality education curriculum in 70 public schools. In partnership with the MOE, they plan to reach all schools in the country over the next five years.

Sudan youth centres undertake similar peer education activities, with a specific focus on developing capacities and skills amongst young men and boys to move away from toxic masculinity and address SRHR topics, especially HIV, without fear of judgment and confidentiality.

In **Syria**, partners provide both material and PSS. Graduates of vocational training courses are provided with vocational training kits. For example, those that complete an International Computer Driving Licence (ICDL) course receive a keyboard and a mouse, or those receiving first aid training are provided oxygen and blood pressure meters to help them practice what they learned.

Some countries also undertake youth programming initiatives outside the context of youth centres or youth-friendly spaces. In **Türkiye**, UNFPA youth programming supports centre staff (including social workers, nurses and health mediators) to go beyond focusing on GBV and SRH and try to help girls become engaged and successful in schools. This is needed to address commonly-seen racism and bullying directed against Syrians, sometimes from teachers or headmasters who may refuse to enrol Syrians. UNFPA is successfully working with these initiatives to build rapport between social workers, schools and youth and increase enrolment. UNFPA also supports catch-up courses for Syrian students in university and courses in Turkish and English. Further, UNFPA in Türkiye is seeking to address a trend among some Syrian parents/families who preferentially send boys to school due to lack of money. Social workers conduct outreach to persuade families to enrol girls – this is leading to increased enrolment rates amongst girls.

In **Lebanon**, although UNFPA does not support any youth centres, a peer education programme empowers and trains young people to avoid harmful practices on SRH and GBV.

UNFPA, as part of its **Türkiye cross-border programming**, implemented an initiative (via partners and co-designed by the UNFPA Amman Hub) that uses a story-telling approach called *Rebel Girls*. This initiative helps adolescent girls to learn from their peers, share their experiences, and enhance their communication and leadership skills. As noted by one adolescent girl: *"I liked this initiative because it allowed me to express my feelings and problems in a new way"*.

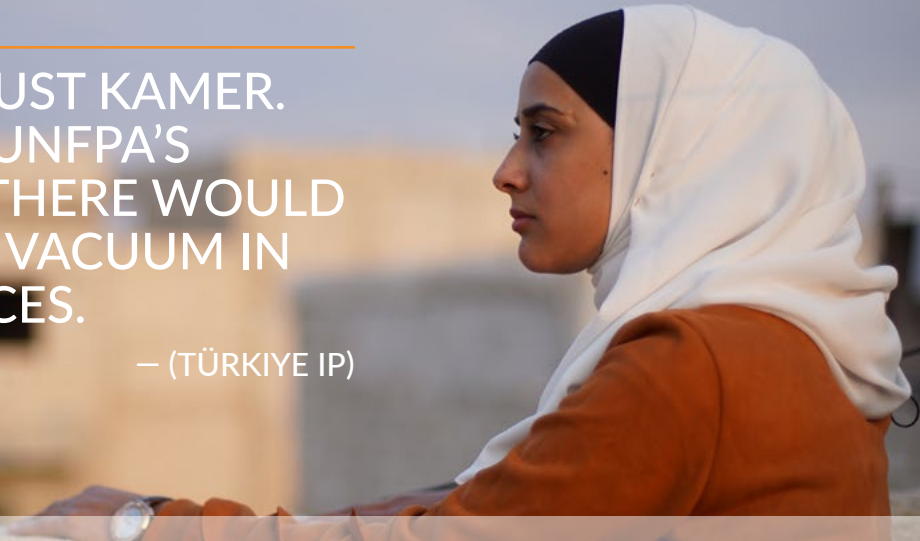
In **Yemen** humanitarian youth work is not yet undertaken, and in **Syria**, UNFPA staff note a substantial gap between what youth need and receive, notably in existing services on education/training and labour market needs, suggesting need for a more systematic analysis of services offered at youth centres or via other training modalities.





PEOPLE TRUST KAMER.
WITHOUT UNFPA'S
SUPPORT, THERE WOULD
BE A HUGE VACUUM IN
GBV SERVICES.

– (TÜRKIYE IP)



DIMENSION B: Access

This dimension of the humanitarian response work that is being undertaken by UNFPA looks at the availability of and access to GBV, SRHR, and youth services to refugees, IDPs and host communities.

Access particularly looks at the challenges faced by people with disabilities or are otherwise vulnerable, and the ongoing or residual effects of the COVID-19 pandemic and associated restrictions on such facilities or services. Data was collected to assess respondent perceptions on the following key points:

- a. How people would address their needs in the absence of the supported facilities or services.
- b. Accessibility of the facilities or services to different groups, including challenges faced and ways to address these.
- c. How services/activities help vulnerable women, girls and youth and the barriers these groups face in accessing the services and ways to address these.
- d. Challenges faced in accessing services as a result of COVID-19, including if attendees have stopped using them, or adaptations that have been made (or could still be made) to facilitate improved services.
- e. CVA programming across UNFPA humanitarian programming and the potential for scaling this modality up, including key challenges.

GBV Programming

a. Addressing needs in the absence of UNFPA support.

For most locations in most country operations, UNFPA is widely-recognised as the only significant player providing GBV support, particularly in camp settings. Some other providers do exist in the GBV sector, primarily NGOs, but many offer a different package of services, and different approaches (e.g. centres open to men, which is a major obstacle for more vulnerable groups).

For example, in **Iraq**, IPs noted that other actors may provide non-core support services such as vocational training or education, but few other centres provide services only to women. This is crucial for ensuring optimal support to women, as traditions and customs don't allow the mixing between men and women in one place.

In **Jordan**, where most refugees supported by UNFPA are in camp locations (e.g. in Za'atari camp), the only other service provider is UNHCR, but it has limited capacity and refers to UNFPA's partner IFH. Outside camps, there are other national and international NGO service providers, as well as government-run family protection departments. However, government facilities and most national NGOs offer limited GBV services as they must report cases to police, a significant impediment to women due to the potential stigma around GBV, especially sexual and GBV (SGBV).

The issue of stigma is also relevant to women and girls accessing government-run services in **Lebanon**, where the cost of services is also a factor.

In **Türkiye**, partners emphasise a high level of trust between service providers and the Syrian refugee population.

"People trust Kamer. Without UNFPA's support, there would be a huge vacuum in GBV services."

– (Türkiye IP)



In **Türkiye cross-border**, the limited availability of SDPs has been exacerbated by the overall funding gap affecting NWS, which has pushed many SDPs to the verge of closure. Thus, UNFPA programming partners highlight the importance and uniqueness of the lifesaving services provided within their services delivery points, since other options within a reasonable distance remain extremely limited. As noted by a service provider:

"There are no other women's centres nearby providing similar services, or they are too far away from our centres. We are also one of the few centres providing support to women over 70 and people with disabilities."

– (Türkiye cross-border IP)

In some of the countries in the region, sustainability/exit strategies have been an ongoing feature of 2021/2022 programming that are intended to create a foundation for GBV support. UNFPA supports capacity building for governments at different levels, but different crises faced in some of the countries present challenges in sustainable building of capacity among people and organisation. In **Lebanon**, for example, the economic crisis means that many key government stakeholders are not being paid (or have had the value of their salaries eroded substantially by inflation), and so are working very limited hours.

This issue is also present in **Sudan**, where high turnover across government departments (particularly since the 2021 military takeover) undermines capacity and requires considerable re-investment in establishing working relationships between stakeholders. Stakeholders noted that GBV work isn't sustainable without UNFPA support. For example, UNFPA provides almost all the funding to the Violence against Women Unit in the Ministry of Social Affairs, which would only have one staff member otherwise. Whereas federal and state government partners in Sudan are supported to work on the policy/legal/SOP and protocol environment, NGO partners work on a wide spectrum of community-based interventions of which the cost of delivery is relatively high.

In **Iraq**, UNFPA has prioritised sustainability in humanitarian programming in 2021/2022, and is actively seeking to hand over facilities and programming to government counterparts. The CO will assess its progress at the end of 2022. However, it anticipates needing several years of support as there are few other independent and quality services available.

In **Türkiye**, many women beneficiaries noted that without UNFPA support they would not venture out of their houses, due to language barriers. Syrian refugees lack information about their rights and entitlements in Türkiye and face challenges in getting access to protection services from government institutions. The centres are filling this gap, by providing the needed information in the targeted population's first language. For appointments in government institutions and other specialised service providers, the centre's staff accompanies attendees and supports with translation. Thus, UNFPA centres are trusted more and held to offer better services than government equivalents.

"[Without the UNFPA Safe Space, we would stay at home awaiting marriage. We would search YouTube to learn knowledge, but there would be no social interaction and no one would listen to us. Here, in the centre, they listen to us. We can meet other people and apply what we learn practically.]"

– (FGD participant, Jordan)



"We have tried other centres but we were not treated with the same level of respect that we found here – although the trainers are sometimes younger than the students. There is no other centre similar to this one. There are other centres, but they do not treat us kindly like here, and they don't offer a lot of services for women."

– (FGD participant, Syria)

"I applied to many centres, but I found the support I wanted most here. The biggest factor for this is that my husband is against it if there are men in centres. There are no men allowed in this centre. This centre is more comfortable for me."

– (FGD participant, Türkiye)

"I do not know of any other place that offers the same services as this Safe Space. If this space did not exist, I believe that I would be living in the streets now."

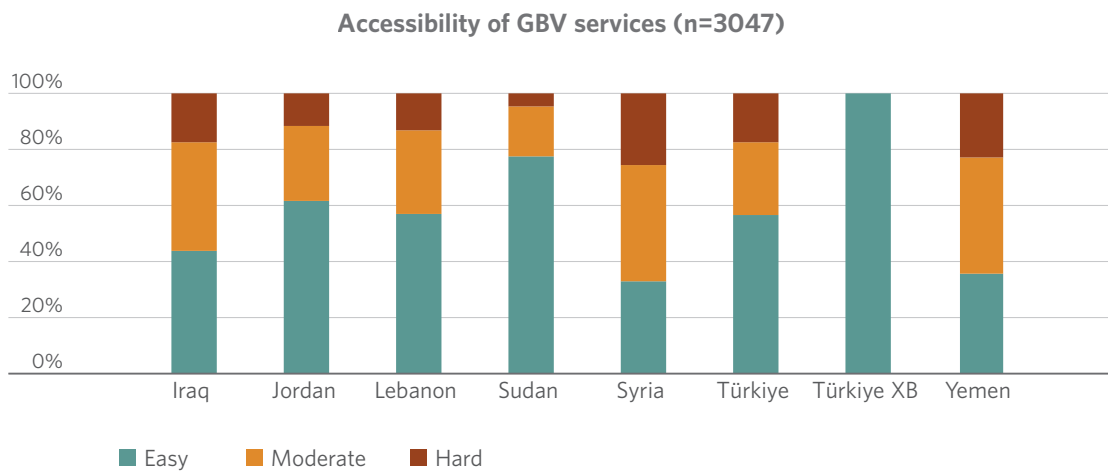
– (FGD participant, Yemen)

b. Accessibility of Facilities & Services: GBV

Physical Access

The accessibility of UNFPA-supported GBV services is a crucial determinant in the quantity and quality of engagement of all who require these services. This assessment listened to the voices of women and girls accessing GBV services to look at the overall accessibility and try to identify any specific challenges they might face.

Figure 33: Perceptions of Accessibility of GBV services by Country



Overall, perceptions of accessibility are quite subjective within and across countries – some respondents are very close to services (e.g. in camp settings in **Iraq, Sudan**), whereas some must travel long distances (on foot or paid transport), whereas in others, UNFPA has subsidised transport (e.g. **Lebanon, Jordan, Syria**).

Access is very easy for ordinary people like us where we can walk to reach the centre, and the centre is located in the middle of the camp.

–(FGD participant, Iraq)

Overall, as presented in the chart, right, most respondents to the assessment found accessibility of GBV services to be easy or moderate. Nonetheless, all response locations other than **Türkiye cross-border** (which had a small sample size of responses, so must be interpreted with caution) saw a deterioration in perceptions between 2021 and 2022, indicating that transportation issues are beginning to affect people more and more.

Some of the participants in FGDs are happy to walk as it provides them with some physical exercise:

Sometimes we manage to get a lift to the centre and sometimes we walk there to take exercise.

–(FGD participant, Türkiye cross-border)

Some respondents, however, are less willing to walk, in some cases due to their or their families concerns about safety.

"It is not easy. Sometimes girls need to convince their parents to let them come . Some give permission but others do not because the centre is far from us and so they fear for our safety. And for others access is easy and free because they live near the centre and the parents themselves will enrol their daughters in the centre."

—(FGD participant, Iraq)

In the countries where UNFPA provides subsidised transport (or transportation allowance), it is much appreciated and can make the difference between attendance or not, particularly if attendees have any disability.

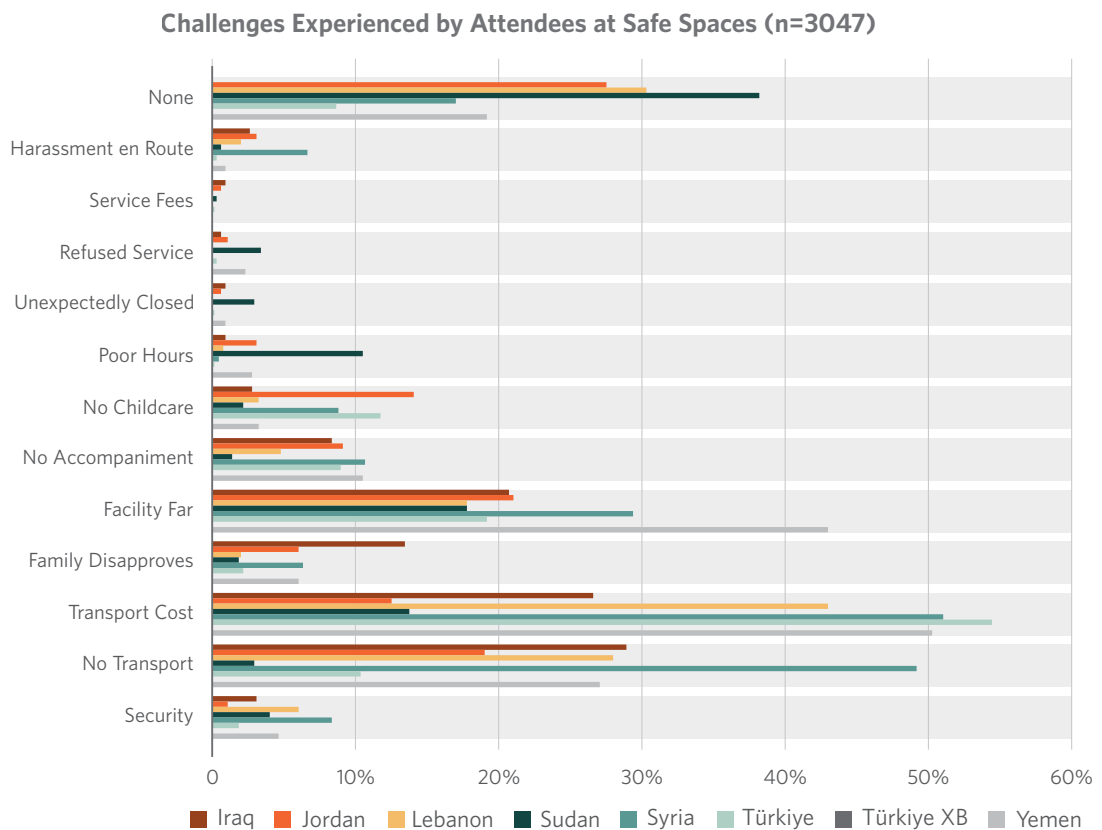
"Transportation is provided and comfortable. Sometimes we walk and sometimes we come by transportation."

— (Türkiye cross-border)

"It takes a half hour to walk there. The car is easier but not when there is no petrol."

— (FGD participant, Yemen)

Figure 34: Challenges Experienced by Attendees at Safe Spaces by Country



Specific access challenges noted by attendees (presented in the chart) were predominantly related to the cost and logistics of transportation – on average, almost a third of respondents to the assessment survey (31%) noted the cost of transportation as a key challenge faced by them. The next most common challenges were the distance of the facility and/or a lack of transportation outright (noted by an average of 21% of respondents for each).

Individual countries experienced these issues to a greater or lesser extent – in **Türkiye, Syria** and **Yemen**, over half of respondents noted these transportation challenges, whereas they were much less significant in **Sudan, Jordan** and **Iraq**, with subsidised transport or short distances to travel.

Although noted in most countries, partners highlighted in **Lebanon** how the economic crisis has led to significant increases in the costs of transportation:

“Taxi drivers often double the cost of transportation when they find out that the centre is located away from the highway.”

– (Iraq IP)

“The economic situation in Lebanon is now preventing many people from having access to services, especially due to the costs related to transportation. Although the organisation is providing support for the cost of transportation, in most cases this is still not enough.”

– (Lebanon Safe Space staff)

In **Türkiye cross-border** programming, UNFPA IPs have actively supported increased access to targeted groups, including PWD and older women, through the provision of free-of-charge transportation services for vulnerable groups. Beneficiaries were actively informed about transportation services through dedicated posts on social media pages and by the camp management. Information service numbers were also shared with beneficiaries in the form of post-it notes through which they could request a car to transport them to the health facility. GBV survivors were prioritised and transported through a confidential communication line between the GBV case worker and the SRH service provider. Medical teams, such as midwives and delivery staff, were also invited to inform beneficiaries about the availability of transportation service in order to facilitate their access to SRH services, such as PNC.

“The hospital is easy to access as it is situated on the highway, but the availability of the transportation from the camp to the hospital is difficult and costly. The pressure of the work is immense as daily caseloads are greater than the hospital can reasonably handle. For non-urgent examinations, the waiting list is several days. We receive 200 daily phone calls, but our capacity is only 40-50, so the staff here are always overwhelmed by the crowds of patients.”

– (Health Facility partner, Türkiye cross-border programming).

An interesting issue captured by discussions with women and girls was the impact of climate on their ease in accessing the centres. The heat in summer is a challenge for those that walk to centres (noted in **Iraq**) and in **Sudan**, women noted how rainfall caused problems:

“During the autumn period, it is difficult for people from south of the valley to reach [services] due to floods.”

– (FGD participant, Sudan)

Security issues in relation to harassment of women or girls by men were noted by participants in discussions in **Jordan, Iraq** and **Lebanon**, whereas in **Syria**, security checkpoints needed to be negotiated. The survey of attendees found that relatively few women and girls reported challenges related to either not having accompaniment (8.8% on average) or experiencing harassment (1.3%), with most of the respondents experiencing harassment being from Syria (3.2%), with no significant difference between the experiences of younger (adolescent) girls and older.

Awareness of Services

Another key dimension of access to facilities is how users become aware of the service being available. This is of crucial importance to GBV work, where survivors of GBV may not know where they can go to receive support or even learn about their rights.

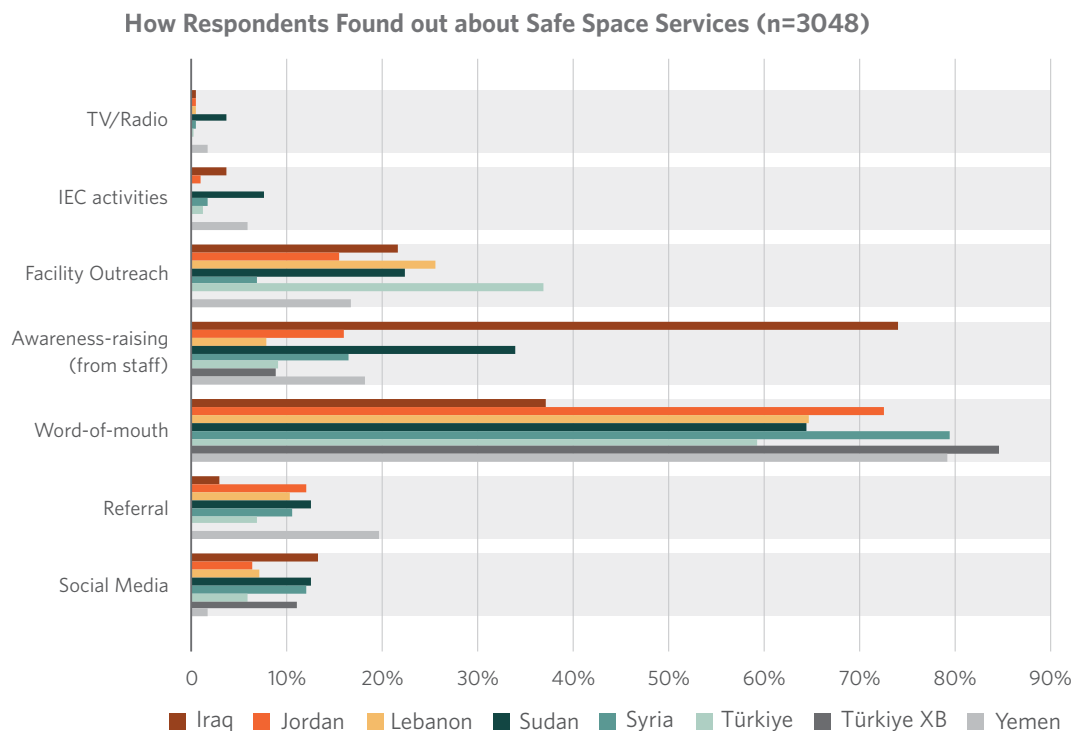
Research amongst attendees at Safe Spaces for this assessment underscores the importance of word-of-mouth to share awareness of the centres – the chart below highlights that it is the dominant means whereby women hear about the services across almost all country operations. In **Iraq**, as Safe Spaces are located within camp settings, awareness-raising by centre staff reaches most people, and outreach activities (for example via volunteers in the communities) is also a significant way to reach women and girls.



In **Türkiye cross-border programming**, mobile and outreach teams also provided information and awareness-raising sessions on SRH and GBV services available in hard-to-reach and remote areas.

Social media (Facebook and WhatsApp, predominantly) and referrals from other organisations are also common means of making people aware of services, with IEC activities and 'traditional' media of television or radio representing a small proportion of respondents, mostly in **Türkiye cross-border programming, Yemen and Sudan**.

Figure 35: How Respondents found out about Safe Space services by country



"[We hear about the Safe Spaces] through friends, the mobile team's field visits, from school, taxi drivers, relatives and online ads.

– (FGD participant, Iraq)

"Through the WhatsApp groups that my sister was participating in, I took the number and contacted the Safe Space."

– (FGD participant, Lebanon)

"My mother was walking near the centre and saw the banner so she entered and asked about the services, so I started coming with her."

– (FGD participant, Syria)

c. Access of vulnerable women, girls and youth.

Vulnerable groups is a key element of the ongoing focus among all UNFPA COs. In most cases, this means working to ensure that services are accessible to PWDs, adolescents and (to a certain extent) the elderly. The table below presents the types of disability reported by UNFPA offices to have active measures for supported services in 2022 (across all services).

Table 4: Types of Disability Services Reported by UNFPA and Partners by Country

	Iraq	Jordan	Lebanon	Sudan	Syria	Türkiye	Türkiye XB	Yemen
Visual	×	×	×	×	×	×	×	
Auditory	×	×	×	×	×	×	×	×
Physical	×	×	×	×	×	×	×	×
Cognitive	×	×		×	×	×	×	
Self-care	×		×		×	×	×	
Communication				×	×	×	×	×

Examples of specific initiatives reported for 2021/2022 by country programmes to enhance inclusion and accessibility for PWDs include the use of transportation adapted to the needs of PWDs to bring them and their support persons to centres (**Türkiye**). Also in Türkiye, women’s centres comply with physical accessibility criteria. Information, education and communication (IEC) material has been developed in 2021/2022 for people with visual or hearing disabilities (brochures on hygiene, GBV and CEFM in Braille, videos for those with hearing disabilities). Some women’s centre personnel have been trained on disability inclusion in service provision.

In **Lebanon**, UNFPA completed a baseline study in 2022 on GBV services for women and girls with disabilities that will inform work for 2023. UNFPA also trained service providers on how to provide GBV services to women and girls with disabilities.

In **Syria**, UNFPA has invested in 2021/2022 to work on mental health, a key driver of disability. This work seeks to target adolescents and youth in Safe Spaces. To overcome the logistical/transportation challenges around this issue, UNFPA has created a “female driver project” – women drivers transport other women from their homes to facilities in rural areas in a safe way, and can even provide limited information and counselling while en route to the centres. This has been well received among both women and men. UNFPA is exploring the possibility of scaling this elsewhere.

UNFPA **Iraq** reports that in the last year a comprehensive programme of physical accessibility of Safe Spaces was undertaken, with all women's centres and camps being equipped with ramps, sign language translation and wheelchairs. Similar efforts are reported in **Jordan** and **Türkiye cross-border**.

"Every year, during the 16 Days of Activism to end GBV, we are able to welcome 25 people with disabilities at our safe space. As a result, most of them decide to enrol in more activities. If a disability prevents the beneficiary from accessing the centre, we provide all the necessary support to help overcome the challenge and allow them to participate in the centre's activities."

– (Türkiye cross-border Safe Space)

UNFPA and partners also report ongoing challenges in delivering GBV services to PWDs. In many countries (**Syria, Sudan, Yemen**) it is an issue related to resources – investing in facilities or in human resources requires funding and/or expertise that is in short supply.

"Services are not always accessible to people with disabilities. It boils down to resources."

– (Sudan CO)

In **Yemen**, the elderly and PWD are reported to be particularly challenging to reach, due to resource constraints in both accessing them and creating materials specifically for their needs. Work by UNFPA and partners in this regard has focused on ensuring supported facilities are physically accessible.

In **Lebanon**, the legacy of COVID-19 was a challenge in reaching PWDs via Safe Spaces. One implementing partner noted efforts in 2022 to coordinate with other NGOs to provide services at their local premises to PWD such as PSS, case management and vocational training. They are hoping to duplicate this effort in other programmes.

A key vulnerable group that is seeing increased attention in 2021/2022 is the LGBTQI community, despite significant challenges in identification and access.

In **Lebanon**, UNFPA has partnered with the NGO SIDC with respect to LGBTQI community on GBV in 2021/2022. This is promising work given the widespread stigma in Lebanon.

In **Türkiye**, UNFPA has a track record of working with vulnerable groups: Key Refugee Groups (LGBTQI refugees, refugee sex workers and people living with HIV), refugee men and boys who were survivors or at risk of sexual violence, and refugees with disabilities (RwDs) and their support persons. UNFPA has established specific services for all these groups that are being implemented through specialised service units. The good practices in working with vulnerable groups are then being scaled-up to all supported service units.

For such groups, stigma and discrimination are still major challenges to effective identification and work. For example in **Yemen**, UNFPA reports that gender identity other than binary is socially and legally



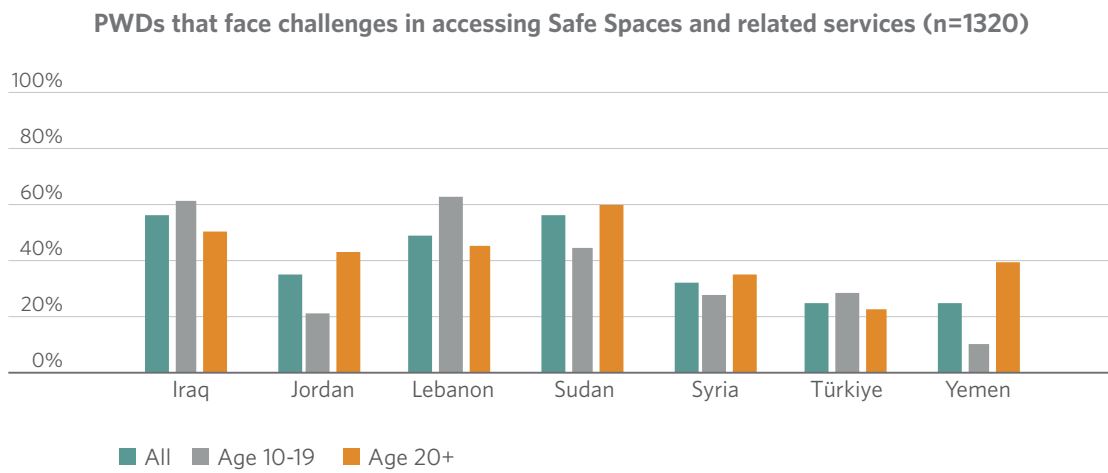
SERVICES ARE NOT ALWAYS
ACCESSIBLE TO PEOPLE WITH
DISABILITIES. IT BOILS DOWN
TO RESOURCES.

– (SUDAN CO)

unacceptable – any deviation leads to capital punishment and any organisation that provides services to such groups would be seen as a supporter and would face closure.

Despite ongoing efforts by UNFPA and partners, many PWDs still report challenges in accessing Safe Spaces. The chart, right, highlights that between one-third and one-half of respondents across the country operations reporting on this found challenges, particularly notable in **Iraq, Lebanon and Sudan**, and significantly for young people in **Iraq and Jordan**.

Figure 36: PWDs reporting access challenges for Safe Spaces/related services by Country

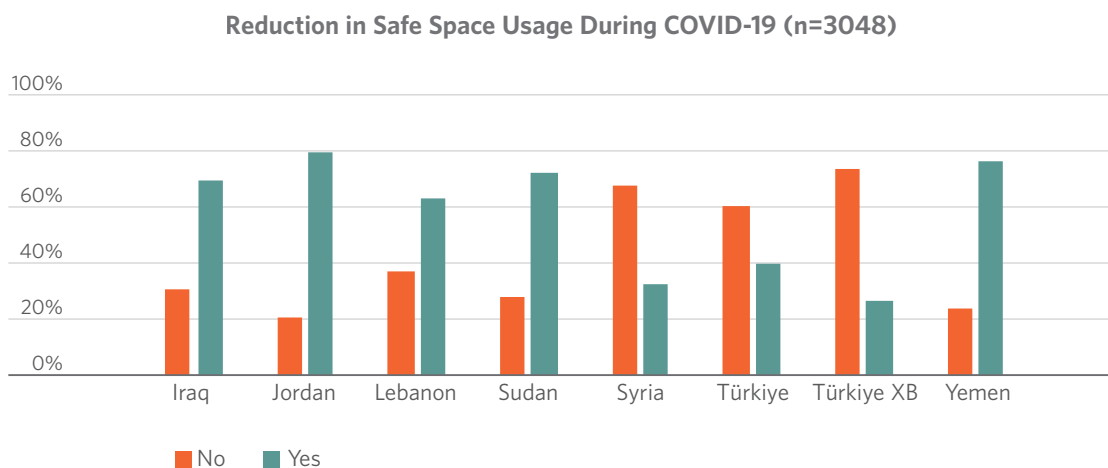


d. Challenges as a result of COVID-19.

The impacts of COVID-19 on GBV programming have diminished significantly over the course of late 2021 and 2022. Most countries reported facing no ongoing difficulties as of mid-2022. While most services were stopped during periods of lockdown experienced by most countries, they remained functional via social media or telephone.

The chart, right, highlights this response across the different country operations. The impacts of COVID-19 on Safe Space access was most noted in **Iraq, Jordan, Lebanon, Sudan and Yemen**, and less so in **Syria, Türkiye and Türkiye cross-border programming**, which maintained limited opening.

Figure 37: Reduction in Safe Space Usage During COVID-19 by Country



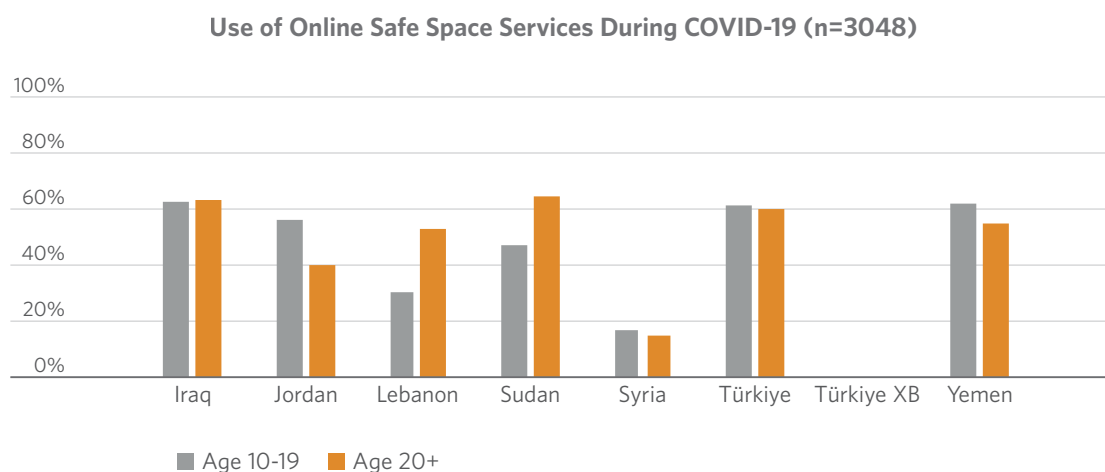


Although the impacts of COVID-19 were documented in detail in the 2021 assessment, some of the key personal challenges noted by women and girls resulting from the pandemic and associated restrictions across all countries were as follows:

- Psychological stress increased.
- Loneliness and depression.
- Increased fear of going out individually.
- Strengthening family relationships.
- Violence has increased, specifically by parents, and men in general.
- Participation in remote enhancing and training courses (language courses).
- Weight gain.
- Isolation from community.
- Unproductive free time caused more problems within families.
- Level of education declined.

Despite wide efforts to transition programming over to alternative means, women and girls reported challenges in internet unavailability, poor networks, power outages were reported across most countries, particularly those with poor communications infrastructure (e.g. **Sudan, Yemen**). Efforts by UNFPA to mitigate these challenges were reported by some countries, e.g. Jordan, where the UNFPA CO supported centres with internet lines, routers, internet credit, Zoom/MS Teams communications accounts. In Lebanon, partners reported an innovative (if somewhat antisocial) approach of implementing services for women and girls late at night (11 pm), when power and internet connections were at their most stable.

Figure 38: Use of Online Safe Space Services During COVID-19 by Country



Across all countries, stakeholders in UNFPA, IPs and community members themselves report things returning to pre-COVID-19 norms, albeit with enhanced protections still in place (e.g. use of masks, distancing, limiting of numbers accessing centres etc) and with all COs having trainings and procedures in place should another pandemic wave present itself.

For example, in **Jordan**, a network of 11 support lines (working hours 8-4pm) and two hotlines (outside working hours and at weekends) are still operating as they were, and they continue to be very popular – some women found these are more private ways to report GBV and receive services.

“We no longer worry about COVID-19. The community is now immune to it. The centre is still committed to a high level of hygiene.”

– (FGD participant, Syria)

“Currently there is no fear. Families have adapted to the situation, and the pandemic is over.”

– (FGD participant, Iraq)

One issue noted in Türkiye and Syria is the phenomenon of vaccine hesitancy, especially amongst pregnant women attending Safe Spaces/WHCC (many of which provided vaccination services).

“There was misunderstanding and fear among pregnant women that miscarriage and stillbirths could occur due to vaccination. Two pregnant women left the centre due to fear of vaccinations.”

– (Türkiye Safe Space)

e. Cash and voucher assistance programming.

Provision of CVA programming for GBV is an emerging area of programme support. In 2021, this assessment reported four humanitarian response countries engaging in some form of CVA programme (**Lebanon, Jordan, Syria** and **Türkiye cross-border**). In 2022, all countries except for **Iraq** were engaging in this modality, and that CO reported being in discussions on a pilot initiative with the UNFPA Humanitarian Office (with training already having been received at CO level). The table below presents a summary of the types of cash, locations, the reported appetite/capacity for scale-up and whether training and/or guidelines on CVA programming had been received or developed by the UNFPA country office.

Table 5: UNFPA Countries and CVA 2022

	Iraq	Jordan	Lebanon	Sudan	Syria	Türkiye	Türkiye XB	Yemen
GBV Cash		×	×	×		×	×	×
SRH Cash		×			×		×	×
No Cash	×							
Scale up scope?	Yes	Maybe	Maybe	Amount, not reach	Yes	Yes	Yes	Maybe
Guidelines/ Training?	×	×	×	×	×	×	×	

*Pilot initiatives.

Cash is provided for a range of purposes across the countries. In **Türkiye**, within the context of GBV prevention and response, key refugee groups and men/boys (ECHO funded) projects, UNFPA provides one-off, short-term cash support, primarily for rent. This is complemented by travel, notary fees and translation expenses of beneficiaries directly covered by UNFPA. A separate US Government (Bureau of Population, Refugees, and Migration) funded project provides cash for HIV medicine.

In 2021, UNFPA **Jordan** launched a pilot to integrate cash assistance within GBV case management. The pilot targeted 260 GBV survivors and women at risk of GBV, both Jordanians and Syrian refugees, also through one-off emergency cash recurrent assistance for three to six months. A study was published in 2022 by Johns Hopkins University comparing the experiences of women receiving only case management with women receiving case management as well as cash assistance. The findings of the study were very positive, with women reporting few challenges in accessing or using cash, meeting a variety of otherwise unmet needs that led to reduced stress, intra-household tensions and GBV and improved psychosocial wellbeing among recipients.¹⁵

One **Lebanon** Safe Space reported reaching approximately 50 people with CVA in 2022 (from six partners and several that Safe Spaces provide cash in GBV case management) and while it reported it to be very useful and beneficial, it highlighted challenges in management due to a need to have careful tools and processes to identify the most genuine needs and impactful cases.

UNFPA **Lebanon** is also providing cash for transportation for all survivors attending case management in 2022 due to high fuel prices as well as providing recurrent cash assistance to people at risk of/survivors of GBV to mitigate risk or respond to needs for up to six months.

In **Sudan**, cash is provided for transport, fees for services, removing the survivor from danger/emergency shelter and providing direct support to survivors of SGBV (transportation, medication costs). In 2021 UNFPA supported 120 SGBV survivors with a one-off emergency cash support.

In Türkiye cross-border programming, IPs report scale up of cash programming in 2022, both within and outside case management. As of mid-2022, one partner had distributed funds equivalent to the entirety of 2021. As well as emergency needs, cash is used for livelihood activities and to cover basic and essential needs, reaching 190 people since early 2021. CVA is also strategically used to promote income-generating activities targeting the most economically vulnerable IDPs, returnees, and host communities' households. Such activities are associated with multiple economic, health and safety benefits for targeted women and their families, while reducing GBV risks.

UNFPA staff and IPs attest to the value of cash in providing vital support rapidly to women, particularly around the isolation challenges faced during COVID.

"Many women have benefited from case management and CVA. We helped a 16-year-old Syrian girl who was raped and had made multiple suicide attempts. She met a case worker and psychologist in our centre, and is now participating in activities, receiving CVA and she is now recovering."

– (Lebanon IP)

"We hope to increase the cash and consequently the beneficiaries as this cash has contributed a lot in reducing cases of violence."

– (Women's Safe Space staff, Türkiye cross-border programming)

"Providing these vouchers every three or four months will contribute greatly to the community's wellbeing. Violence and divorce in the community will be reduced, and children will be protected from exploitation."

– (Safe Space staff, Türkiye cross-border programming)

¹⁵ UNFPA, JHU, Expanding the Evidence Base on Cash, Protection, GBV and Health in Humanitarian Settings, September 2022 <https://jordan.unfpa.org/en/publications/risk-choice-cash-within-gbv-case-management-jordan-1>

Almost all country programmes see scope for expansion of cash programming in some form. In **Jordan**, UNFPA notes a need to focus and target more, and will review the finding of the assessment of the pilot to determine the scope for increasing (if money is available) .

“In light of the positive effects that cash assistance is having on women and men in relation to their GBV concerns, we recommend increasing the focus on the usage of cash.”

– (Lebanon Safe Space)



Cash comes with some specific challenges, however. In countries facing financial crises, such as **Lebanon**, the high rate of inflation means fixing a cash amount in local currency is difficult, and changing amounts within the same budget is often not feasible. One potential solution is UNFPA Lebanon’s plan to pilot a voucher system for 2023.

In **Yemen**, cash is used by some partners to support the referral of some SGBV cases and some emergency obstetric complications. UNFPA is also scaling up its utilisation in 2023 to increase the uptake of services, especially by the GBV survivors. Partners report the use of cash as impactful, but severe funding limitations mean choices may be required in the future between the impact of scaling up cash or using available funding to reopen closed facilities.

Sexual and Reproductive Health & Rights

a. Addressing needs in the absence of UNFPA support.

There are more stakeholders engaged in SRHR activities in the UNFPA operational countries, unlike GBV, which has a considerably smaller pool. In countries with better-functioning health infrastructure, state (and some non-state) actors are in a position to provide at least some services related to SRHR. For example, in **Jordan**, the Jordanian MOH does provide public healthcare services, and UNFPA has worked in 2021/2022 to ensure refugees have access to ANC/PNC and FP via 550 public health facilities around the country free of charge (or for a nominal charge for some services).

NGOs – both national and international – continue to provide another layer of healthcare in many operational countries. In **Yemen**, IPs note the presence of NGOs such as Medicines Sans Frontiers, SCI, Binaa and organisations supported by the Government of Qatar that provide SRH services complementary to UNFPA, as well as mobile clinics, supported by UNICEF that provide primary health care and antenatal care.

Some responses are working on building sustainability. For example, in **Iraq**, UNFPA is working on transition plans with the government to hand over RH clinics in the coming year. SRH clinics will be moved from camps to host community primary health care centres. This was achieved for the first camp (Baserba, Erbil) in conjunction with UNHCR in 2021/2022, and is working on a second camp (Kawergosh) up to the end of 2022. Nonetheless, these strategies mean services will become susceptible to the challenges faced by national healthcare infrastructures. In **Iraq**, an assessment by UNHCR before handover saw big gaps in

support to staffing. The government hadn't managed to secure resources and informed the assessment team that it could not recruit staff (especially female doctors) due to financial constraints.

However, despite the presence of other actors providing some SRH services, UNFPA in 2022 continues to support either a higher quality of service (noted by IPs in **Jordan**), or specific SRHR services that are not available elsewhere (e.g. CMR in **Jordan** and **Yemen**, fistula surgery in **Sudan**) or free of charge (many operational countries).

"UNFPA supports 27 partners in SRH with salaries, equipment, electricity etc to make sure everything is running. If they stopped it'd be a huge impact. Many of the mobile teams are the only providers in many rural communities – they wouldn't have any kind of ante- or postnatal care without them."

– (Syria CO)

In **Sudan**, UNFPA supports the access of women to SRH services and particularly obstetric referral through establishment of community-based obstetric referral mechanisms. Members of these mechanisms were trained, equipped and funded for referral of pregnant women to health facilities for better services. UNFPA provides direct support through cash for transportation and maintenance of ambulances. UNFPA Sudan in 2021 also introduced and piloted the use of community-managed "tuk-tuks" (three-wheeled motorised transports) for rapid, free transport for pregnant women.

Further, in some countries with camp-based populations (e.g. **Iraq, Jordan, Sudan**), access to outside health facilities is not feasible, increasingly so as the cost of transportation continues to rise and funding reductions constrain service provision (e.g. Za'atari Camp in Jordan had eight actors providing SRH services in 2020/2021 but as of 2022 only has three to four, which is insufficient to meet demand).

"I can say that we are the institution that provides the most reliable, comprehensive and specialised service in Reyhanlı. If we weren't here, it would definitely be more difficult for women. It would also be difficult for women to access family planning methods. Speed of access to services would drop."

– (Türkiye Health Facility staff)

"[Without UNFPA support] refugees would have to go to the outpatient clinic for foreign nationals. Because they are refugees, family doctors would not accept them and they therefore would not access any services."

– (Türkiye Health Facility staff)

"We have been the only facility providing the services continuously without interruptions since 2019. There were others, but they have stopped. There are two other women's centres near Jinderes and inside Jinderes, but they are providing different services."

– (Türkiye cross-border Health Facility staff)

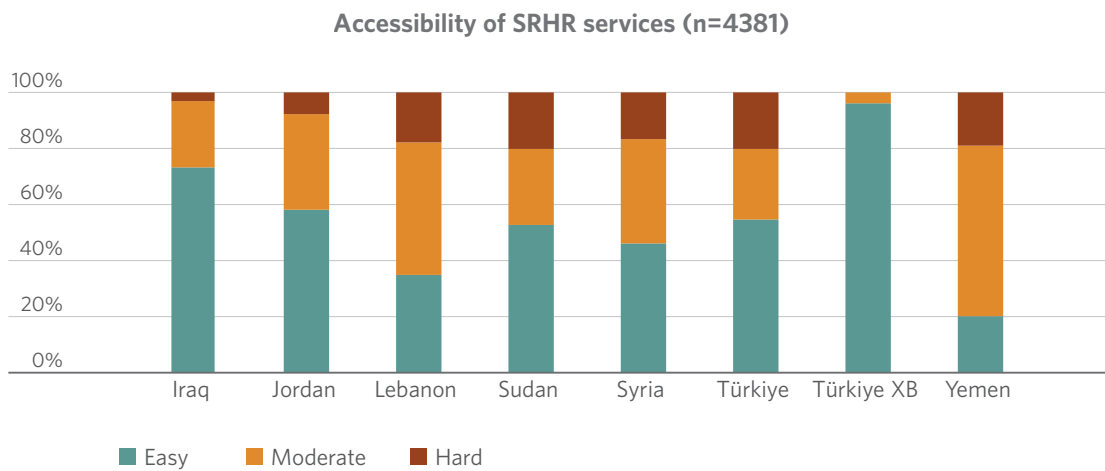
In other countries, notably **Sudan**, without UNFPA supported SRHR services and clinics, women would not have any access to SRH services. Midwives have little or no equipment and UNFPA-provided RH kits have enabled provision of services (kits 6a and b), and in clinics with kits 2a and 2b.

Similarly, in **Yemen**, UNFPA support to medical staff means they do not leave for private sector work, which is a common phenomenon. One facility that was supported by UNFPA had the first ever caesarean-section in 2021 with a UNFPA-supported doctor. Without such support, up to a million people with access to UNFPA-supported services would no longer have this, and in particular no access to family planning, as the government would not allocate resources to this service.

b. Accessibility of Facilities & Services: SRHR

In general, users of SRH facilities found them to be similarly accessible as GBV facilities, with most respondents considering them “easy” or “moderate” in terms of accessibility. Access was deemed to be difficult by more respondents in **Sudan, Türkiye** and **Yemen** (approximately 20% of respondents in each country). Results were exceptional in **Türkiye cross-border** programming, where 96% of 150 respondents to the survey found accessibility of services ‘easy’ and the remaining 4% found it ‘moderate’ with no respondents finding access ‘hard’.

Figure 39: Accessibility of SRHR services by Country



Specific challenges faced by attendees at supported health facilities were focused primarily around transportation issues, as with GBV – with distance of the facility, the cost of transport or the availability of transportation the three main challenges noted by respondents in all country operations, despite efforts by UNFPA and partners to mitigate this issue.

In **Sudan**, UNFPA is circumventing transportation and access challenges in conflict-risk areas for ambulances by renting passenger cars for emergency cases (such as women in labour). In 2021/2022 it supported 40 of these in Kassala state and is planning to roll this service out in Gedaraf state in 2023.

“The financial barrier is enormous – transportation is unavoidable as Sudan is so large. We try to bring activities as close to the affected people as possible, but transportation is always required.”

– (UNFPA Sudan CO)

Issues of accompaniment and family approval with respect to attending health facilities were also highlighted by respondents, with **Iraq** a particular issue – IPs noted issues around social norms and customs in Iraq being a particular challenge where women/girls needed to travel to attend centres.

c. Access of vulnerable women, girls and youth.

Most measures supported by UNFPA in SRHR to address vulnerability focus on the access of PWDs to services. In **Iraq**, for example, UNFPA included disabilities in its annual work plan in 2021/2022, seeking to include PWD in all interventions. In 2022 it undertook training of MOH focal points in the KRI on how to deal with PWD in primary health care clinics. It also implemented a range of measures to make SRH clinics disability-friendly with ramps and trained service providers on disability related issues, with monthly reporting on numbers of PWD attending SRH services becoming mainstreamed.

In **Jordan**, health facility partners are cooperating with Safe Spaces to address any challenges that vulnerable groups (e.g. adolescents, widows, survivors of GBV) face in accessing Safe Spaces, via home visits that include awareness sessions for husbands about the importance of visiting clinics. Any survivors who have issues or fears around attending Safe Spaces can avail of a confidential counsellor at the health facility. Also in **Jordan**, UNFPA has worked in 2022 to combat the perception that SRH is for pregnant women only, and not for unmarried youth, men, boys – so they are working to normalise SRHR for all.

In **Türkiye cross-border programming**, UNFPA continued to undertake targeted efforts to ensure that all groups facing intersecting forms of discrimination, such as PWDs and older women, have effective access to supported services. As confirmed by TPM reporting, targeted efforts have been made to improve the accessibility of the facilities, for instance by building wheelchair ramps, installing handrails, and modifying accessible toilets. Activities engaging PWDs and older women have been organised in ground floor rooms. Older women and PWDs have been actively encouraged to take on leadership roles in organised sessions with the objective of building their self-confidence and self-respect.

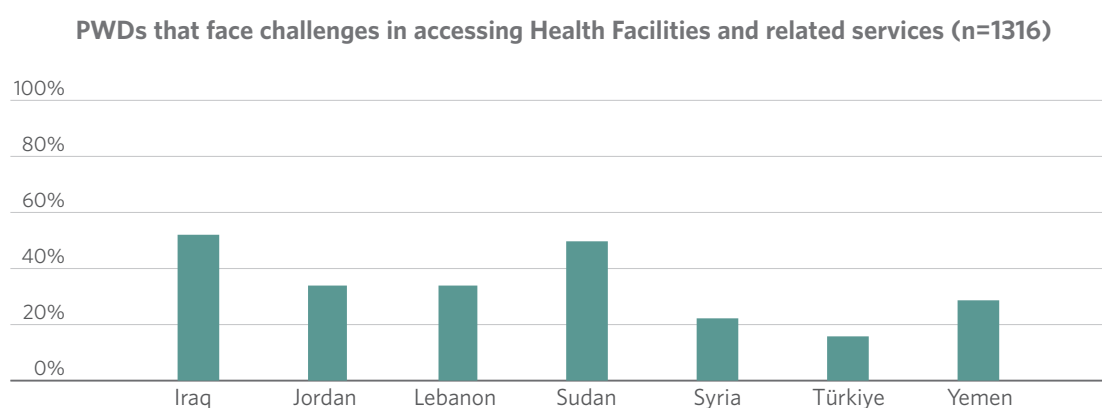
“Access to the centre is easy, even though I’m disabled. Transportation is provided to me and my friends.”

– (FGD Participant, Türkiye cross-border programming)

In **Sudan**, UNFPA has advocated successfully for the legal age for sexually-transmitted infection (STI) testing to be reduced from 18 to 15. Sudan has an increasingly visible adolescent key population (LBGTI, sex workers), particularly in response to more difficult economic circumstances that are pushing people to sex work, so this is a very timely intervention and will be coupled with increased availability of testing services at supported health facilities. Another concerning trend in Sudan is an increasing prevalence of “virginity testing”. UNFPA has advocated against this in 2022 and trained service providers to provide counselling against the practice.

There is an acknowledgement amongst stakeholders for a need to tailor services more to vulnerable groups.

Figure 40: PWDs reporting access challenges for Health Services by Country



While all countries acknowledge progress in providing services increasingly for their main constituents (refugees/IDPs and women and girls), many note a need to do more in terms of the quality of services for PWD and more vulnerable groups, in particular members of the LGBTQI community.

In **Yemen**, for example, health facility staff note that PWD have limited access to their facility, and a consistent excess of demand over supply for all service and all people, not just vulnerable groups.

This is reflected in perceptions of PWDs themselves that were included in the assessment survey (presented in the chart, above). On average, a third of PWDs noted challenges in accessing health services, with the highest levels in **Iraq** and **Sudan**. Given that respondents to this survey were already present in facilities (the sample was drawn from attendees within the facilities themselves), there is likely a bias in response, and many even more vulnerable attendees could not access the service to respond.

Accessibility of SRH services to key populations such as LGBTQI groups is showing increasing progress across UNFPA country operations. In **Sudan**, UNFPA has continued work in 2022 on HIV prevention among men who have sex with men (MSM) and sex worker populations. This is particularly challenging work as sex work and MSM is highly culturally unacceptable in Sudan. UNFPA has advocated with donors to work in locations with higher vulnerabilities and not just sex workers/MSM but also clients and relatives etc. Donors are prioritising assistance to areas of higher vulnerability in 2022 (e.g. areas with higher STI prevalence, or higher humanitarian need), not just clinical services, but training of care providers and supportive supervision.

In **Jordan**, UNFPA has started work on LGBTQI issues in 2021 with internal training. These will be disseminated down to partner level in late 2022/2023. It is planning to report on numbers of LGBTQI people served in programming once service providers are adequately trained on how to collect these numbers.

In **Lebanon**, UNFPA-supported programming is building on progress from previous years. Staff of health service providers are trained to provide services to LGBTQI people, but the emergence of an anti-LGBTQI movement in Lebanon means facilities do not receive many cases. UNFPA has supported several trainings in 2021/2022 on outreach for this sensitive topic. In particular, the economic crisis has led to challenges in increased sex work – more so among gay or trans men. UNFPA has deepened its partnership with NGO partner SIDC on integrated GBV/RH approach with LGBTQI community members in Beirut/Mount Lebanon. An evaluation of UNFPA Lebanon work concluded in 2021 found that UNFPA-supported health facilities were preferred by LGBTQI individuals than government services because they felt more comfortable and safer attending these.

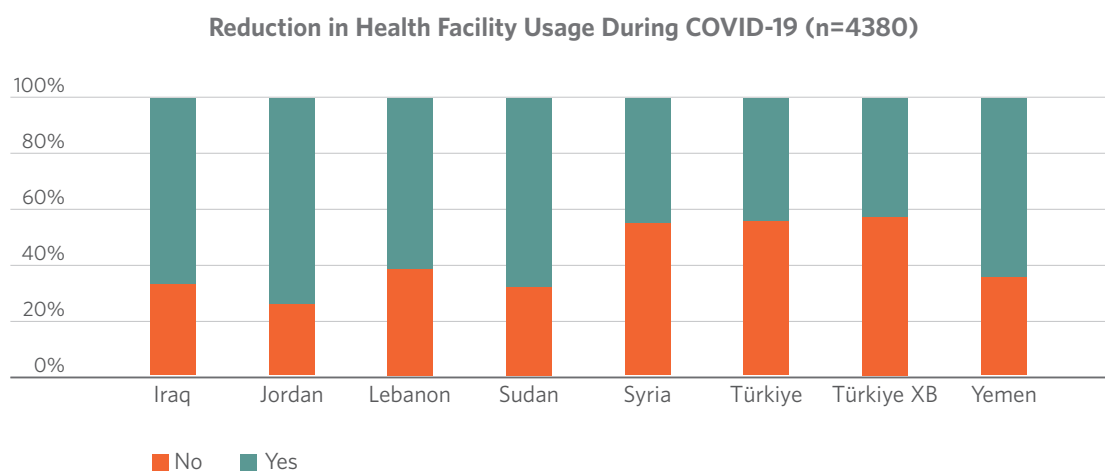
d. Challenges as a result of COVID-19

It is clear that delivery of SRHR services was greatly impacted by the COVID-19 crisis. The chart, right, indicates the high proportion (59% on average) of people that reduced their usage of health facilities.

As with GBV programming, late 2021 and 2022 saw a gradual reduction or lifting of restrictions on movement and access, and a general return to pre-COVID-19 ways of service delivery, albeit with limited precautions still in place, and preparations made for any needed ramping up of measures.



Figure 41: Reduction in Health Facility Usage During COVID-19 by Country



NOW, WITH THE VACCINE AND AWARENESS, THE ISSUE HAS BECOME NORMAL.

— (LEBANON)

Health actors, however, are more cognisant of the risks of successive waves of infection, so many health service providers are maintaining a state of readiness to act quickly to safeguard their staff and services in this eventuality.

“Now, in 2022, life begins to become normal, and goes back to how it was before COVID-19. But it isn’t a complete recovery. We mustn’t forget that COVID-19 goes in waves. In the last two months, there has been a new wave and an increase in cases.”

— (Iraq Health Facility staff)

IPs and service provider staff across all countries reported a range of awareness sessions on COVID-19 throughout late 2021 and 2022, and either provides vaccines directly, or shares information on vaccine availability and undertakes IEC campaigns to encourage the public to become vaccinated.

Many health partners report the ongoing normalising of COVID-19 amongst the population.

“COVID-19 is generally dealt with as a normal flu. People are no longer afraid of it.”

— (Iraq)

“Now, with the vaccine and awareness, the issue has become normal.”

— (Lebanon)

“Now, COVID-19 is no longer a source of fear or danger. We are more concerned about monkeypox.”

– (Sudan)

This said, some health partners note the legacy impact of COVID-19 responses on other areas of health care provision. In **Yemen**, partners report a lack of funding for other health programmes has led to shortages in medicines, medical tools and operational cost, forcing some centres to be closed for lack of resources.

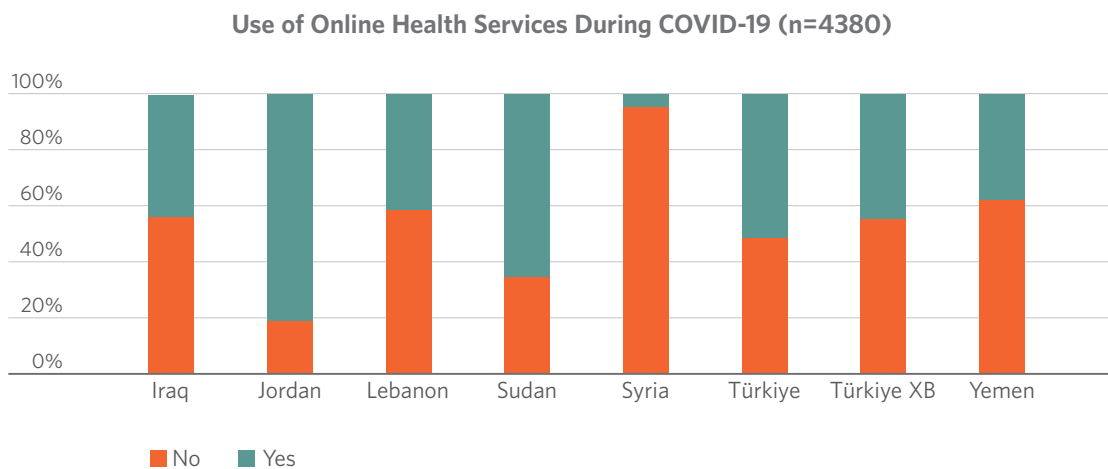
It is also clear that the pandemic is not over – in **Jordan** an implementing partner noted that while they are scaling back their COVID-related activities, cases were increasing again:

“Last week we had to close the office due to many COVID cases. We have had to reinstate some precautions.”

– (Lebanon IP)

The prevalence of online usage of health service shown in the chart, right, is testament to the popularity of these services. Although there is considerable variation across countries (from 5% in **Syria** to 80% in **Jordan**) an average of two-thirds of respondents used some form of online health service over the COVID-19 pandemic period.

Figure 42: Use of Online Health Services During COVID-19 by Country



Some of the programmatic dividends of COVID-19 responses remain – in **Lebanon**, a telehealth SRH service supported by UNFPA was piloted in 2021 with the Lebanese Social Worker Syndicate and Family Health Society. An evaluation of the pilot was very promising and it will be taken forward at scale in 2022/2023.

Most UNFPA programmes are still implementing precautionary measures with respect to COVID-19 – limiting size of training, PPE, avoiding large gatherings, although the trend is for fewer and fewer of these and they are agency-mandated rather than government. A key consideration amongst some of the humanitarian responses is that COVID-19 has been one of many virulent communicable diseases, so did not attain the same profile as in the developed world. For example in **Sudan**, 3-4% of people contract malaria every year – so COVID-19 “doesn’t even make the top five of general worries in the country” (UNFPA interviewee). In many cases, the priorities are the legacy impact of COVID-19 on supply chains and logistics having a direct and indirect impact due to lack of services and supplies.

e. Cash and voucher assistance programming.

Syria provides the most significant example of CVA being provided as part of SRHR programming in 2021/2022 (although the project is managed under GBV programming as it enhances protection and dignity through access to hygiene materials). In Syria, UNFPA is implementing a joint CVA project with the UN World Food Programme (WFP) that provides pregnant and lactating women with cash for hygiene materials in addition to cash for food. Following a successful pilot from May-August 2020 in Dara'a, the e-voucher programme was extended in September 2020 to 12 of the 14 governorates of Syria. From January-June 2022, the programme reached over 99,338 unique pregnant and lactating women, averaging 67,000 women a month. In addition to cash, UNFPA partners provide information on SRH and GBV services. To qualify for the voucher the woman must have a pregnancy certificate issued by a UNFPA or MOH-supported clinic. This initiative is not only an opportunity to support households with food and hygiene items – very critical in and of themselves – but monitoring by WFP (quantitative data) and UNFPA (qualitative data) has very positive feedback in terms of family food security and hygiene security and better understanding of services available and importance of services. Ongoing reporting by the initiative from 2022 found that the majority of recipients of the assistance attended SRH and GBV sessions either at registration, or at UNFPA-supported clinics. There was a recognised need for additional capacity strengthening on this, with UNFPA and WFP agreeing on a set of information sharing/capacity building sessions on this, targeted to all stakeholders starting from September 2022. A 2022 evaluation of UN joint programming in Syria noted the success of this initiative, although it recommended that such joint initiatives be better linked to resilience programming.

UNFPA **Türkiye cross-border** programming has started an innovative pilot initiative to address barriers faced by mothers while accessing PNC services using conditional cash assistance. Despite its critical importance, PNC is among the most underreported services in the region due to a number of contributing factors, including the cost and availability of transportation, lack of awareness and deeply rooted social norms that do not encourage mothers to leave their homes during the first 40 days after birth. To help mitigate these barriers, UNFPA has developed a unique programme that provides conditional cash transfers to beneficiaries of PNC to incentivise service uptake and help beneficiaries offset transportation costs.

Jordan has reported plans for some interventions in relation to cash and SRH. It is not clear that cash is a major issue affecting accessibility of SRH services (although family planning services may be more affected), so UNFPA is still gathering evidence on this before they take next steps in 2023.

Finally, **Lebanon** launched a pilot initiative on conditional cash for menstrual hygiene management in the third quarter of 2022.

Youth Programming

a. Addressing needs in the absence of UNFPA support.

In the countries where UNFPA supports youth centres, partners note some other facilities that could provide services to youth in the absence of UNFPA. In some cases these are somewhat similar to UNFPA-supported services, but others differ in fundamental ways. For example, in **Sudan**, partners note the presence of a cultural centre that includes or is open to youth as part of their overall service for the public, but is not specifically targeted at young people.

“It is possible to find a theatre because it is a private place and it may accept different cultural activities. But, you can't find similar sports activities like ours because the spaces here are unique. So you might find culture activities but there are no sport activities.”

– (Sudan Youth Centre staff)

Similarly in **Jordan**, the youth centre in Za'atari camp is the only centre specifically for youth, and it is mostly run by Syrian youth. Other centres in the camp are community centres that serve all groups and have

different ways of doing activities. The diversity of activities and the positive support and atmosphere were highlighted by young people as being a unique and very strong feature of the UNFPA-supported centre.

In **Syria**, partners report few facilities which undertake youth-specific programmes or training or set aside Safe Spaces for young people. The youth centre supported by UNFPA in Aleppo serves approximately 3,800 beneficiaries, with the numbers of young people who are in need of its services more than the capacity of the facility. In Quneitra in southern Syria, the youth centre supported by UNFPA is the only one in the area.

In **Iraq**, there are other youth centres but they are mixed, and thus less useful for young women and girls.

"Parents prefer this centre because it is intended for women only. Things would be much harder if this centre didn't exist."

– (FGD participant, Iraq)

Young people participating in discussions highlighted the work that is supported by UNFPA – most of them say there are no other centres that provide youth services for them. Many young people noted that other facilities or clubs are not free of charge, and hence affordable for them.

"Yes, there are other centres, but you have to pay for their courses, which are very expensive. Therefore we would have to pay a lot of money in exchange for the same services we get here for free."

– (FGD participant, Syria)

"[Without the UNFPA centre] we would suffer, especially without learning courses. I registered previously in several centres but nothing happened. Here [at the Safe Space], they believe in you and I found opportunities."

– (FGD participant, Syria)

b. Accessibility of Facilities & Services: Youth

As with GBV facilities, there are a mix of perceptions between users regarding the accessibility of youth facilities and services. Logistical considerations are the most significant challenge faced by young people – for some, the centres are located close to their residences (especially within camp settings), and walking is feasible and sometimes desired. For others, the distance is too far to walk, and public transportation is either expensive, or perceived to be unsafe (especially for young women).

"It is easily accessible for those who live in the city centre, but it is considered far for those who live on the edges of the city."

– (FGD participant, Iraq)

"Access is easy because the centre is located downtown in a strategic location near the transportation route, which makes it safe."

– (FGD participant, Sudan)

For some youth in Za'atari Camp in Jordan, the hot weather of summer and the cold wet weather of winter makes travel across the camp a challenge.

Knowledge of the centres and their activities is typically through word of mouth, although information on social media plays a more significant role for youth than with other services, not surprisingly.

"We hear about activities through social media and friends who used to come to the centre before."

– (FGD participant, Iraq)

"We hear from friends and relatives and from the adverts for vocational training on the centre's Facebook page."

– (FGD participant, Sudan)

Figure 43: Accessibility of Youth Services to Youth 10-19 by Country

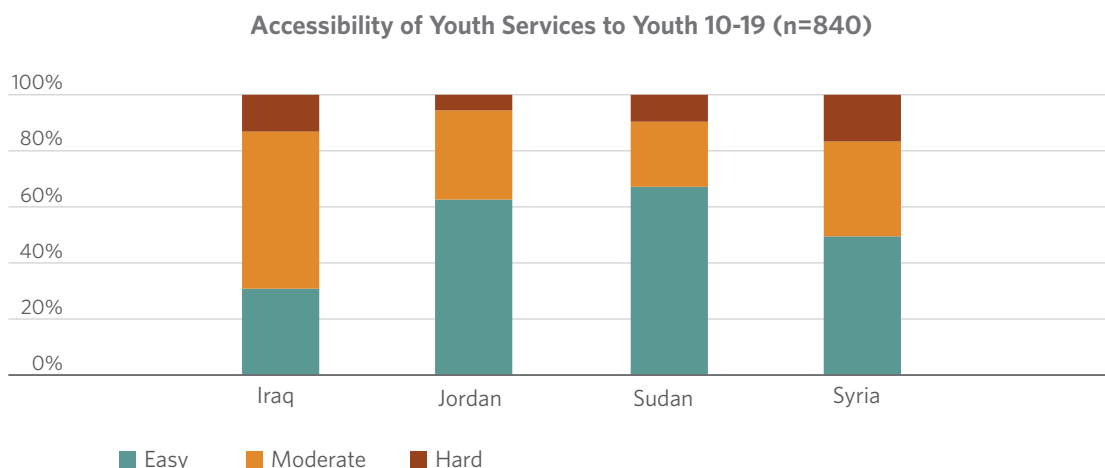
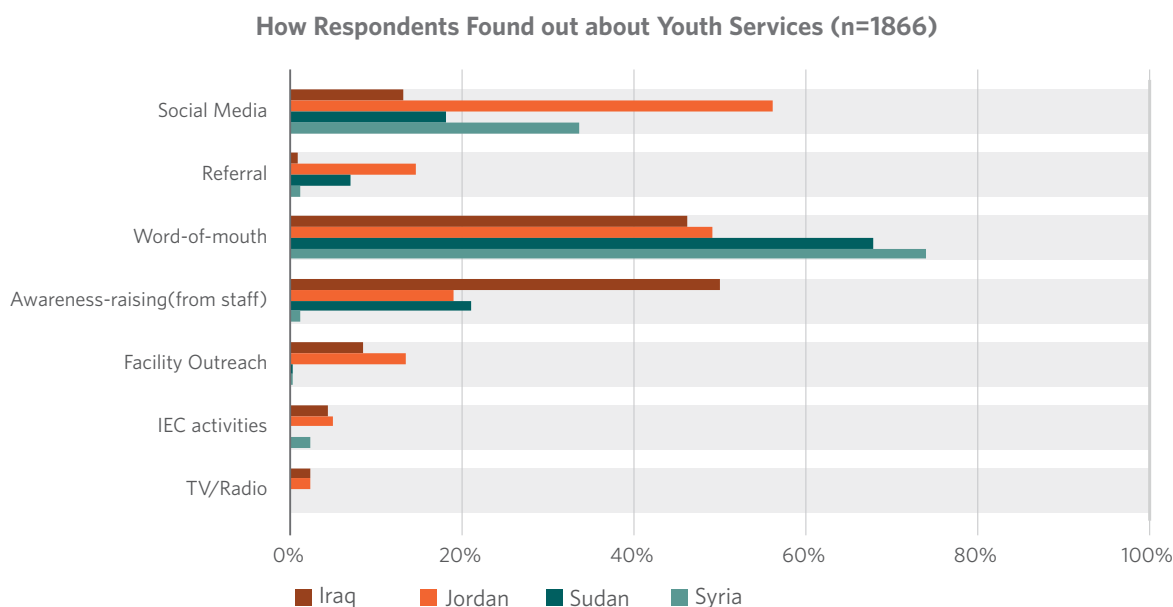


Figure 44: How Respondents Found out about Youth Services by Country



c. Access of vulnerable women, girls and youth.

UNFPA-supported youth facilities report strong efforts to reach as many as they can. As with other facilities, accessibility measures for physical disabilities are the easiest, as (noted by UNFPA Syria) “young people will make every effort” to access social/recreational and learning services when there are few other options. Stakeholders note greater challenges in creating accessibility for youth with visual/mental disabilities, but some achievements have been made in 2021/2022. In **Syria**, the annual UNFPA work plan with the MOE has



a section on transforming the school curriculum to Braille. Many youth with disabilities were also supported under livelihood and community participation elements in 2022 – work that continues into 2023.

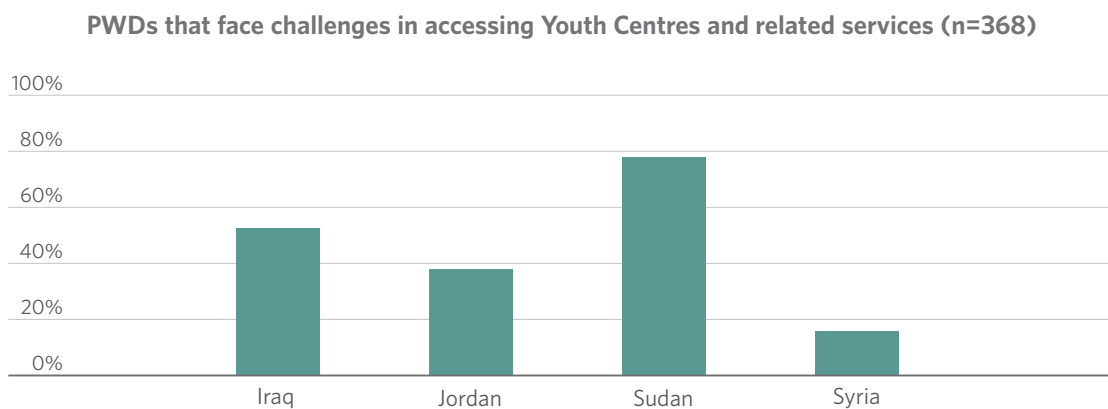
In **Sudan**, partners note challenges in reaching youth with disabilities and other vulnerable groups due to limitations on the services or the equipment which satisfy their needs.

In **Syria**, young people interviewed highlighted how their centre was equipped to support young people with disabilities.

“There were people with disabilities with us in courses and activities who became our friends. The centre provided support that they wouldn’t get elsewhere.”

– (FGD participant, Syria)

Figure 45: PWDs reporting access challenges for Youth Services by Country



d. Challenges as a result of COVID-19.

The impact of COVID-19 restrictions was particularly felt by young people, many of whom had few other outlets for social, educational or other activities, and whose socio-economic status was more vulnerable to restrictions and limited employment opportunities. The chart, below, highlights the proportion of youth in the four countries with active youth centres that noted limitations on their access during the pandemic. Restrictions were most severe in **Jordan** and **Sudan**, and least in **Syria** where only 18% of young people noted being restricted from accessing centres. Some of the specific challenges noted by youth in discussions for this assessment were:

- Lack of training and learning opportunities.
- Increased problems among family members due to psychological stress within households.
- Inability to leave their households.
- Challenges with online activities due to limited internet connectivity.
- Health deterioration from lack of activities.
- Weight gain and physical fitness deterioration.
- Isolation from peers and community.
- Deterioration in learning/education and skills.

Figure 46: Reduction in Youth Centre Usage During COVID-19 by Country

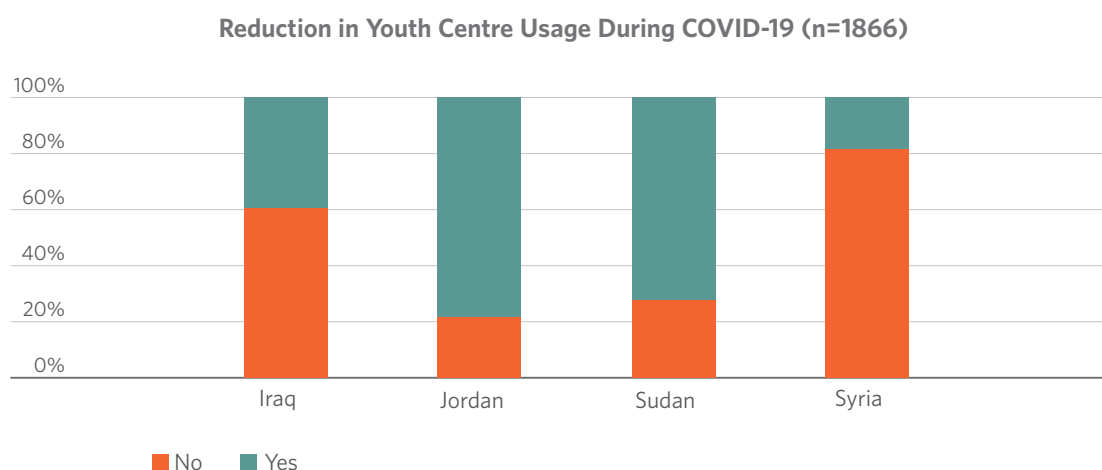
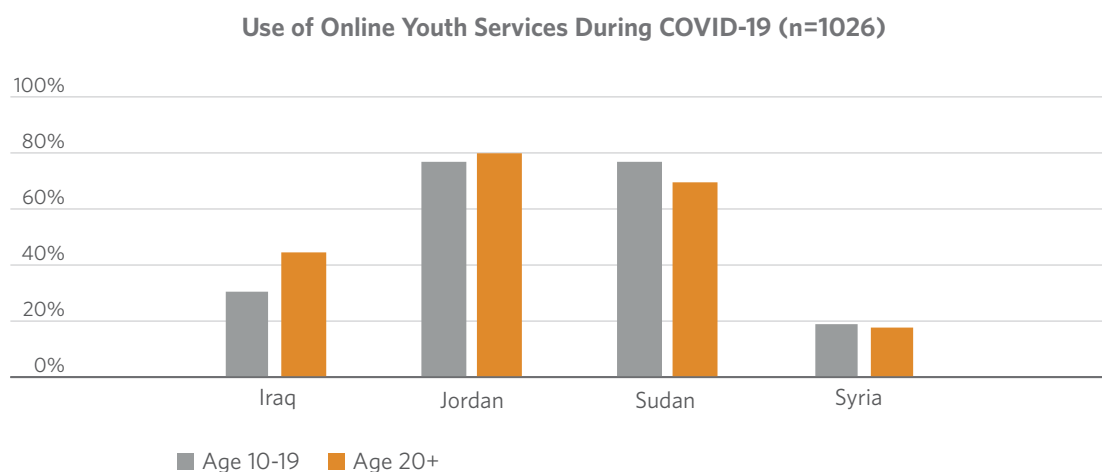


Figure 47: Use of Online Youth Services During COVID-19 by Country



As with other sectors, these issues affected young people mostly during the 2020-2021 period, with the introduction of movement and access restrictions in communities and facilities. Late 2021 and 2022 has seen a progressive lifting of restrictions to the point where, as of mid-2022, very few precautions were still in place.

"In 2021-2022, there haven't been any kind of problems concerning COVID-19 as most people have kept following health precautions. Also, most people believe that the COVID-19 pandemic has come once, and it will not come back again. Now, the situation in the centre is good."

– (Sudan IP)

Young people and youth centre staff did highlight the value of online services during COVID-19 restrictions – IPs highlighted how the online services were useful, particularly as young people are more technologically literate than adults.

Internet connectivity was, however, challenging for some, noted specifically by youth in **Jordan** and **Sudan**. Indeed, many young people included in this assessment noted reaching saturation with online services, and are very happy to once again interact with their friends and peers in person.

"We have forgotten about COVID-19. Our needs as young people are greater than the fear of the pandemic."

– (FGD participant, Sudan)

In **Syria**, youth centre staff noted ongoing use of online services to reach young people who cannot visit the centre – some youth live far away from the centre and they cannot regularly visit due to the transportation cost, and in some cases young women/girls that may otherwise not have been permitted to travel to the centres can avail of the online services instead, thus allowing them interactions that might otherwise not have been possible.





DIMENSION C: Efficiency

This dimension has been consolidated across GBV, SRHR and youth programming and service providers.

a. Human resources adequacy and needs

Availability of staff for GBV services over 2021 and 2022 has been variable across different response countries. For some Safe Spaces, there are adequate case workers, outreach workers and volunteers to ensure smooth running of the facilities. For example, in **Jordan**, IPs report that there is no shortage of community health volunteers that are locally hired, and want to work. In **Iraq**, reductions in funding for some partners in 2022 meant a reduction in Safe Space staff, but they are managing to provide all key services with the existing staff, albeit with limitations on outreach activities (e.g. awareness-raising outside the Safe Spaces).

"Before, we had five employees inside the camp, and they helped a lot in raising awareness as the camp is very big. Now, we are only two employees, and we are not enough to cover the need for awareness raising inside the camp. If we got more employees, our awareness-raising outreach would be much better."

– (Iraq IP)

For other partners and service providers, human resources is a challenge. Another implementing partner in **Iraq** noted that the available staff "is absolutely not enough compared to the services and the targets", and the limitations of staff available for the Safe Spaces that they manage means that services need to be curtailed and women and girls will not receive the needed care.

"We have only one GBV case worker and one psychological therapist for five centres and she can only come once in the month to each centre (I don't think the beneficiaries will keep coming). We need more. Also, we have only one girl and one young man in our mobile team."

– (Iraq IP)

In **Lebanon**, Safe Space staff note that UNFPA funding for facilitators can only cover one facilitator who has to help approximately 2,300 beneficiaries.

“One facilitator isn’t enough as there are many quality services to be provided, in addition to administrative work and reporting. There is a minimum standard of services to be provided. It is not a matter of attending a session and leaving some elements out – there are aspects that can’t be ignored. We have agreed with UNFPA to hire two facilitators on a part-time basis which is not ideal at all.”

– (Lebanon Safe Space).

For health facilities, as skillsets become more specialised, staff become harder to recruit and retain. The lack of specialist medical staff has been noted by many implementing partner and facility stakeholders, as well as being well-recognised by community members seeking care. For example, in **Jordan**, partners report difficulty in recruiting gynaecologists for public work as they prefer to work in the private sector where they earn more. The prevalence of service contracts only (vs. permanent contracts) is another impediment to recruiting in-demand specialists. Similarly in **Lebanon**, many doctors have emigrated over the course of the past three years as a result of the economic crisis. The economic crisis in Lebanon means that many government staff have seen their salaries (pegged to an out-of-date official exchange rate) hugely eroded by inflation, so many are not working full hours and those that are present are poorly motivated, which is a significant issue.

A further challenge noted by partners in **Sudan** and **Türkiye** is the high level of turnover of qualified and experienced staff, often from national NGOs to higher-paying and higher-status international organisations or donor-funded projects/programmes (e.g. SIHHAT in Türkiye). This was exacerbated by the COVID pandemic, which disrupted normal patterns of work and led many people to change their work permanently. UNFPA **Türkiye** reports seeking to increase salaries of WHCC staff to be more competitive to prevent brain drain to other service providers, but funding limitations are a key challenge to this.

There are particular challenges in retaining staff at field level where many of the services are delivered and where the greatest value of services is generated.

“National civil society partner staff are trained and then get recruited to international organisations, or people in the field move to Khartoum. We also see brain drain out of the sector or out of the country.”

– (Sudan CO)

Another challenge noted by UNFPA **Sudan** was the disruption caused by the political upheavals following the military takeover in 2021. This led to a wide range of civil servants being replaced – in some cases repeatedly. New staff are frequently appointed on the basis of political affiliations rather than skills so UNFPA needs to train and retrain every year.

“Ministry of Health staff had no handover, no data collection capacity. We need to start from scratch every time.”

– (Sudan CO)

This sentiment was echoed by **Türkiye cross-border programming**, although as a result of funding cuts, which, in 2022, pushed many SDPs to the verge of closure. This has increased the caseload of UNFPA-supported facilities exacerbating shortages of staff and overcrowded spaces.

“We need more staff for the clinic as it is always overcrowded with patients.”

– (Türkiye cross-border health facility staff)

“In the delivery unit, we have two midwives, a resident doctor and an obstetrician to provide services to 20-25 delivery cases every day, and to follow up the postnatal cases of the caesarean delivery which may reach seven deliveries every day. As such, we don’t have enough staff in the delivery unit.”

– (Yemen health facility staff)

b. Training and capacity (including user perspectives)

As part of work towards its mandate areas, UNFPA provides a wide range of training across GBV, health and youth programming for partner staff both in technical and peripheral administrative and IP programme management areas such as budgeting, proposal writing, and M&E.

In GBV and SRHR programming, UNFPA has continued its support in 2021/2022 in development of technical expertise and supporting capacity building of partners both at field level or within the SDPs and on various topics. Partners attested to how UNFPA provides a variety of training to fit different levels of knowledge and expertise.

For example, an IP in **Lebanon** noted a strength of UNFPA capacity building is the presentation of choices for training so they can select the most relevant to their needs.

The table below presents a (not exhaustive) snapshot of training topics reported by partners and service providers over the course of 2021/2022.

Table 6: Training Topics Reported by Partners and Service Providers 2021/2022

Iraq	Jordan	Lebanon	Sudan	Syria	Türkiye	Türkiye XB	Yemen
Early Marriage	Case Management	SRH	In-service health	GBV	SOP Training	GBV	GBV
Child Protection	Working with LGBTI	SRH	Family Planning	PSS	GBV	ANC	Case management
GBVIMS	PWD	GBV	EMONC	Counselling	Health intermediaries	CTG	PSS
MHPSS	sGBV	Safeguarding	GBVIMS	Case Management	Social Workers Supervision Training	SRH	Strategic planning
Life Skills	Girl Shine	PSEA	CMR	M&E	Parental Privacy	CMR	M&E
Covid-19	Life Skills	PSS curriculum	GBV	ICDL	Working with Key Refugee Groups	Infection Control	Referral Pathways
Cholera	SRH	Impact Assessment	Case management	First Aid	PWD Awareness	PNC	MISP
PSS	Treatment Quality	GBVIMS/ Primero	TOT	SRHR	PSS	Warehouse Management	GBV
	Working with LGBTI	MHM Coaching	PFA	Finance/Admin	Child Safety	Project Management	CMR
	Referrals	GBV Coaching	Mental health	GBV	Addiction TOT	Report Writing	Case management
	GBVIMS	NEX training	Case management	SRH	Digital Violence	GBV	
	PSEA	P2P SRH	GBV	PSEA/ counselling	Counselling	SRH	
	Cash Assistance M&E	GBV	PSS	Finance/Admin	PSS	Online Safety	
	CMR		Covid-19 awareness	PSEA/ counselling	Online Privacy	PSEA	
	GBV				PSEA	Integrating Elderly	
	Trafficking				Youth health	PSS and PWD	
					Personal Data law	Child protection	
				Girl's Services	Case Management		
				Supervision and Self-Care	Protection Mainstreaming		
				Health Outreach	Safe Spaces		
				PWD Awareness	CMR		
				GBV			
				PSEA			
				Communicable Diseases			

IP HF Safe Spaces

All partners and service providers underscored in interviews and discussions the importance of training for both ongoing professional development but also to deal with the above mentioned issues of staff turnover.

For example, in **Sudan**, UNFPA provided training in 2021 for judges on legal provisions related to GBV. Feedback from the recipients indicated that many were not aware prior to the training of how the specific provisions in Sudanese Law related to GBV, particularly rape – many were made aware for the first time of the importance of robust medical examination evidence in order to secure convictions of perpetrators.

In 2022 UNFPA **Türkiye** provided AAP sensitisation and information provision about complaints and feedback mechanisms to all partner staff including SIDA-supported women's centres, developed a standardised complaint and feedback mechanism, AAP SOPs for all women's centres, integrated feedback mechanisms into the UNFPA online data collection system and plans to conduct training of partners to strengthen accountability in 2023.

In **Lebanon**, despite having a vibrant civil society sector compared to others in the region, the capacity of NGOs is still quite limited and thus UNFPA has continued to implement a core capacity development pillar – implementing training directly via sub-consultants and training organisations, while acknowledging the need to redouble efforts to meet targets and sustain quality of work.

The table below presents feedback from different stakeholders on the types of training that they would like to receive in the coming year from UNFPA. As can be seen, there is a very wide range of technical and general areas that partners feel they need to successfully implement planned activities.

Table 7: Types of Training Requested by Partners in 2023 from UNFPA

Iraq	Jordan	Lebanon	Sudan	Syria	Türkiye	TXB	Yemen
GBV	Family Planning	GBV	EMONC	GBV	Legal training	SRH/STI training	MVA
TOT	IUD implantation	Legal Support	Midwife training	PSS	First Aid	Clinical trainings	Complaint Mechanisms
Time management	Ultrasound	CVA/Case Management	GBV	ISDL Advance	Work with LGBTI	Project Management	Computer Skills
	SRH Counselling	Work with LGBTI	MHPSS	Family PSS	Family Planning	PM+	Report Writing
	Midwife Training	M&E	PWD training	Psychotherapy	Counselling	CMR	GBV
	Breastfeeding		GBV	Case Management	Social Work	Specialised ToT.	
	Cash transfers			PSEA	Psychology	Problem solving	
	Vulnerable groups			SRH	Climate Change	Emotional intelligence	
	Communication Skill			Counselling	IEC Skills	FGD (in depth training).	
	Data Skills				Refugee law	Report writing	
Legend	Self-care				Temporary protection	Case Management	
IP	Stress Management				Legal basis of GBV	MHPSS	
HF	Administration				Work Permit procedures	GBVIMS	
WGSS	Case Management						

In **Lebanon**, partners note increased needs in 2021 and 2022 for M&E staff and skills due to increased donor reporting demands for accountability of scarce funding and seeing the impact of programmes, thus leading to new indicators and tools.

Partners across most country responses increasingly report the need for training on use of various digital tools for data collection and management (GBVIMS, REMS, ActivityInfo, Primero) which take time and effort to learn, but note that the quality of data is very good when complete and can work well to show donors a clear picture of progress and programming.

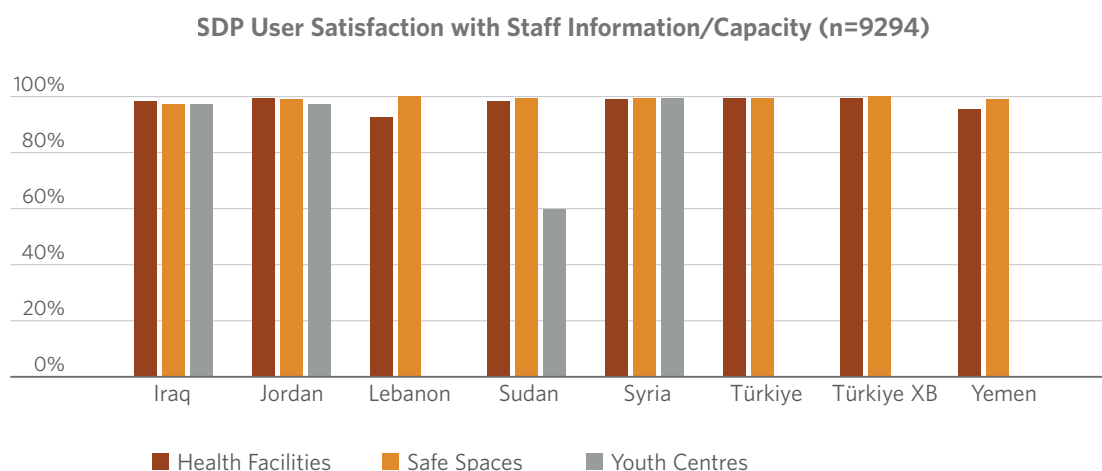
As with many community members making use of SDPs, several partners noted the utility of conducting so much of the training remotely when COVID restrictions were in place, but that as restrictions (and concerns) abate, there is a clear and widespread preference to return to more in-person training and interactions.

I prefer to attend these courses personally so we can get more information, in addition to the social interaction. It is much better to receive regular training. The online training is not as useful as the real one.

— (Syria Safe Space)

The assessment also sought feedback from community members on their satisfaction with the information and capacity of the staff operating within the various SDPs across the three mandate areas and humanitarian responses (see chart, right).

Figure 48: SDP User Satisfaction with Staff Information/Capacity by Country and SDP



Overall, the perception of staff quality was very high amongst users – in most cases over 90% of respondents were happy with the staff. The only divergent perceptions were in **Sudan**, where fewer attendees at youth centres expressed satisfaction with the staff information and capacity, suggestive of some issues to be addressed (related to the institutional upheavals around the change of government in Sudan in late 2021).

c. Facility Adequacy and Needs

Many facilities across the response operations report having good (or adequate) facilities and equipment. Many also note that they could always do with additional support, but are doing the best they can with what they have. Others, if they have adequate supplies, express that they feel “lucky”, and thus it is clear that expectations are that shortages are the norm.

In some countries (e.g. **Türkiye cross-border**) maintenance of equipment is proving challenging due to a shortage of funding. Some health facilities report that technical equipment (e.g. incubators), are old and in line for replacement. UNFPA continues to work to provide required equipment in line with available funding, but not all needs can be met.

“There is equipment available for five hospitals out of eight, and that is all. We have specified our needs for the second delivery of equipment after installing and commissioning the first. Two weeks ago, we received a very big amount of equipment from UNFPA. As the governorate faces a lot of emergencies, the demand for these materials is high. This is why the need is huge. UNFPA support is very welcome.”

– (Sudan Health Facility staff)

Some of the challenges noted by SDPs via interview are:

- Insufficient material for some of the vocational training courses (Iraq Safe Spaces, Sudan Safe Spaces, Sudan IP, Syria Safe Spaces, Türkiye cross-border IP)
- Inadequate electricity supply – no generators or no money for fuel for generators (Iraq IP, Syria HF)
- Poor drinking water supplies (Syria HF)
- Some medical devices are old and in poor repair (Jordan IP, Lebanon HF, Türkiye cross-border HF, Yemen HF)
- Health facilities in very poor repair (Sudan CO)
- Poor access to computers (Jordan IP, Türkiye cross-border Safe Spaces)
- Insufficient material for some social/cultural activities, e.g. sports, languages (Jordan YC, Sudan YC, Sudan IP, Syria Safe Spaces, Türkiye cross-border Safe Spaces)
- Inadequate resource material for PSS activities (Türkiye cross-border Safe Spaces)
- Good equipment, but not enough (or no) staff to operate it (Yemen HF, Sudan HF)



I PREFER TO ATTEND THESE COURSES PERSONALLY SO WE CAN GET MORE INFORMATION, IN ADDITION TO THE SOCIAL INTERACTION. IT IS MUCH BETTER TO RECEIVE REGULAR TRAINING. THE ONLINE TRAINING IS NOT AS USEFUL AS THE REAL ONE.

– (SYRIA SAFE SPACE)





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— (SYRIA SAFE SPACE)



d. UNFPA RH Kits and Commodities

UNFPA has continued to provide dignity kits and RH kits as part of its programming to most countries. UNFPA COs, IPs and service providers all confirm the vital role that RH kits, mother and baby kits and hygiene/dignity kits play in providing essential and lifesaving medical services at one extreme, and supporting a dignified life on the other.

In some of the UNFPA countries of operation, deteriorating funding environments for refugees and IDPs mean that medical facilities cannot access essential medicines, and deteriorating economic conditions mean that women cannot afford hygiene/sanitation items. Challenges in procurement were reported in 2021/2022 by **Sudan, Türkiye** and others. A continuum of declining donor interest pre-2022 has been exacerbated by a diversion of attention to Ukraine in 2022.

“There is definitely an unmet need for family planning materials. Migrant Health Centres currently cannot get any of these from the government – UNFPA tries to contribute, but stocks are insufficient to meet demand. Also some women cannot be reached as they are too far from centres – they cannot afford transportation.”

— (Türkiye CO)

In **Iraq**, RH kits – stopped between 2019 and 2021 on request from the MOH in Baghdad as the list of kits didn't pass approval – restarted again in 2021/2022. The procurement plan for that year saw deliveries of family planning supplies to the MOH in Baghdad and KRI.

In **Türkiye cross-border** programming, UNFPA remains the sole provider of SRH medicines and supplies to NWS. In 2022, UNFPA continued to tranship essential goods and supplies through the Bab-Al-Hawa crossing-point providing lifesaving and life sustaining assistance to affected populations.

In **Jordan**, family planning supplies were also reported to be a challenge sometimes, but generally kits are extremely useful, although a five-month delay between order and receipt reported by one partner (ordered in January 2022, but received in May) is a challenge to effective service provision, particularly as local procurement is not permitted in Jordan. Family planning supplies used in UNFPA supported clinics are procured by the MOH. The only RH kit that UNFPA Jordan procures is Kit 3, for providing post-rape care to survivors.

In **Lebanon**, a shortage of contraceptives was seen in 2022, which UNFPA was seeking to resolve with the Ministry of Public Health (MOPH) to ensure proper forecasting. UNFPA noted a substantial increase in consumption due to increased attendance at primary healthcare providers due to the economic crisis.

Similarly in **Türkiye**, there are increased demands for family planning supplies as government-supplied products to Migrant Health Centres from local health directorates and service units have experienced stock-outs over the 2021/2022 period.

In **Yemen**, medical and laboratory supplies, and medicines are provided, but cannot meet the needs. Kit 3 and 10 (Post-Rape treatment and Manual Vacuum Aspiration kits) are permitted and distributed to all health facilities in need in the South where the CMR protocol is approved and being used. In the North, a CMR protocol was recently approved (late 2022) but Kits 3 and 10 are not fully approved for distribution - some components of the kits are removed by the authorities and the rest are approved for distribution.

Sudan also is experiencing shortages of RH Kits 1-12, across the board. UNFPA Sudan reports only covering 30-50% of the needs. UNFPA procures a lot of family planning supplies but there is always a big shortage and stockouts of FP supplies at local level, and also life-saving drugs. UNFPA reports that supplies may be at federal level, but don't make their way to local level due to issues with national logistics and supply system from federal to state level (Sudan CO). The military takeover of 2021 (and conflict in the lead up to it) was a key issue – a suspension of the port of entry in 2021 had a negative impact on the national logistics system with many aid items suspended in port. This led to high demurrage costs due to a backlog of items, while poor storage of items affected quality, which then required testing, and some were destroyed during unrest.

Sudan also experiences issues with last mile supply due to ongoing unrest, although in 2022, UNFPA was trying to solve this challenge. As free-of-charge items from aid agencies impact on revenue generation by the government system (they charge some user fees) – there is some competition between aid actors and the government system.

In **Lebanon**, UNFPA report an ongoing need for post-rape treatment kits (Kit 3). UNFPA has worked with the Lebanese MOH on CMR in 2021 and 2022 and developed a national strategy and action plan, as well as working on facilities and conducting ongoing training through 2022. Implementation of the strategy and action plan is the next (and ongoing) step, including proper forecasting and management of kits. UNFPA has worked with the WHO and the Government to build a new warehouse for supplies storage as the previous one was destroyed in the August 2020 Beirut blast. The blast also caused critical damage to the national management system, so UNFPA is working through this.

e. Ongoing Challenges, Solutions and Support

The following challenges and suggestions/areas for support have been noted by UNFPA CO staff, IPs and service provider staff across the various country operations:

General

- Substantially increasing transportation and utility costs (electricity, water, internet) can be mitigated via more community-based work (e.g. via outreach volunteers).
- Project basis of work (i.e. short-term focus) with implementing agencies and centres means they can't plan strategically or commit to investments in facilities or staff.
- Due to shortages in commodities, kits, supplies and limitations in logistics systems in-country, more prepositioning is needed.
- Bureaucratic challenges in dealing with government, particularly where there is high turnover or poor incentives due to economic crises (and the COVID-19 legacy) requires redoubled advocacy, especially to effect policy change.
- Climate change is leading to more extreme weather affecting marginal settlements/camps and access to remote facilities.
- Building sustainability in crisis-hit countries is becoming increasingly difficult, made worse by a lack of government capacity and deteriorating donor interest. There is a need to redouble resource mobilisation efforts across all three mandate areas.
- Year-on-year decreases in funding as the crises become prolonged and other crises (e.g. Ukraine) take hold.
- Stress and overwork among centre/IP staff.
- Outbreak of new health crises (e.g. cholera in Syrian and Lebanon).

- Transition from COVID-19 crisis to economic crises globally.
- Increasing tensions between host communities and migrants/refugees/IDPs.
- Increasing use of (and demand for) cash assistance modalities need to be matched with better training and SOPs as it is a new area for many countries. Countries highlighted that plenty of expertise in UNFPA and in the region that can be drawn upon (e.g. Lebanon, WFP, UNHCR, UNICEF). Some COs (Syria) are developing their own SOPs.
- Poor management dialogue – perceptions that IP/SDP voices and feedback not fully attended to.
- Results/targets should be adjusted to reflect the ongoing challenges and changes in context.

Women and Girls' Safe Spaces

- Materials for social/cultural/vocational training courses – not just to run the courses, but to incentivise women to attend (courses provide an entry point for IEC activities).
- Cash assistance for emergency needs for GBV survivors is either unavailable or insufficient to meet demand (noted in Iraq, Lebanon, Sudan, Syria).
- Stigma or fear around reporting of violations by women is an ongoing challenge.
- Cultural inhibitions prevent women and girls from attending Safe Space activities, particularly younger women/girls.
- GBV social norms changes are a long and slow process that face cultural and sometimes policy challenges. Advocacy with governments and IEC focus on males is needed.
- Delays in kit procurement.
- Administrative delays for IPs in starting up projects – need faster turnaround from UNFPA.
- Integrating different services for centre participants, e.g. linking PSS to livelihoods to build sustainability along the nexus – including (potentially) small livelihood grants or livelihood partnerships with other organisations/cash-for-work.
- Maintaining the appropriate balance between distribution of cash/material and provision of protection services. It's important they do not become 'relief distribution points'.

Sexual and Reproductive Health & Rights

- Economic deterioration means increasing numbers of people are seeking lower-cost or free health care vs. private providers.
- Medications shortages or outright bans on some (contraceptives, PEP kits, SRH supplies).
- Identifying and retaining health specialists – many are moving to the private sector due to lack of consistent funding for their roles.
- Issues of vaccine hesitancy around COVID-19.

Youth Programming

- Limited capacity to target specific (non-mobility-related) disabilities, particularly among youth – awareness sessions with parents are useful in meeting this.
- Attracting parents to participate in training in youth centres is a challenge.
- Youth centre work doesn't often fall under a specific funding stream (health, GBV, livelihoods), so it is difficult to attract dedicated funding.



DIMENSION D: Comparison of key impact assessment datasets between 2022 and 2021

Below are some visual comparisons of key data sets from the 2021 assessment and the 2022 assessment. An important consideration is the impact of the increase size of the dataset from 2022, that offers stronger statistical power, and hence certain comparisons with a smaller dataset from 2021 may be less robust or generalisable. Assuming the same size dataset is available for 2023, more robust and valid comparisons using the 2022 and 2023 datasets will be possible, as will comparisons between the two additional countries (**Sudan** and **Yemen**), unavailable for this year.

Dimension A (Wellbeing): Importance of accessing services

Perceptions of the importance of accessing services among users of UNFPA-supported services have seen a consistent increase between 2021 and 2022 across all three service deliver points, a reversal of decreases seen between 2020 and 2021, potentially a reflection of the return to services after restrictions imposed following COVID and a renewed sense of the value of the services. Safe Spaces saw a 9% increase in perceptions of being “absolutely essential”, health facilities of 19% and youth centres of 34%. In most cases this was matched by a corresponding reduction in the proportion of respondents considering them “very important” and other categories to a lesser extent.

One deviation from this trend was an increase in “little to no importance” increase between 2021 and 2022 driven by spike in Türkiye (WHCC/HF), Lebanon (HF) and the inclusion of Yemen (18% “little or no” for Safe Spaces in 2022), which skewed results somewhat.



2021-2022 by SDP *Figure 49: Importance of Accessing Services*

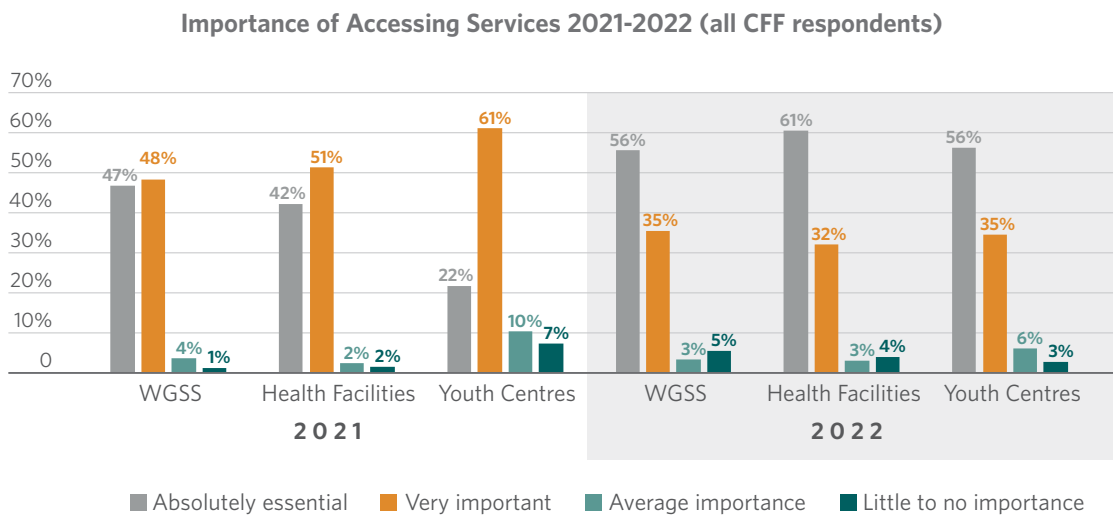
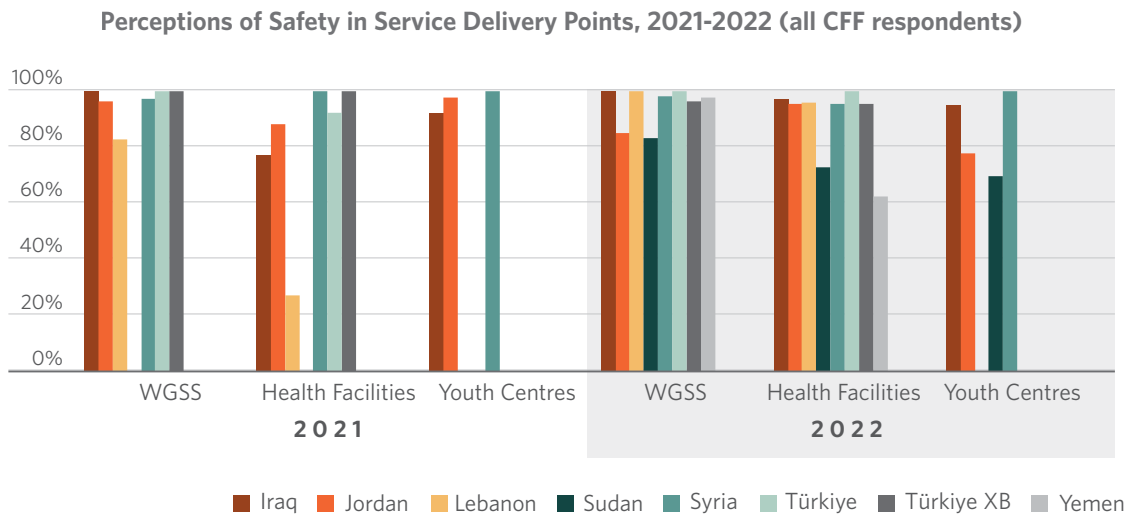


Figure 50: Perceptions of Safety in SDPs, 2021-2022 by Country and SDP



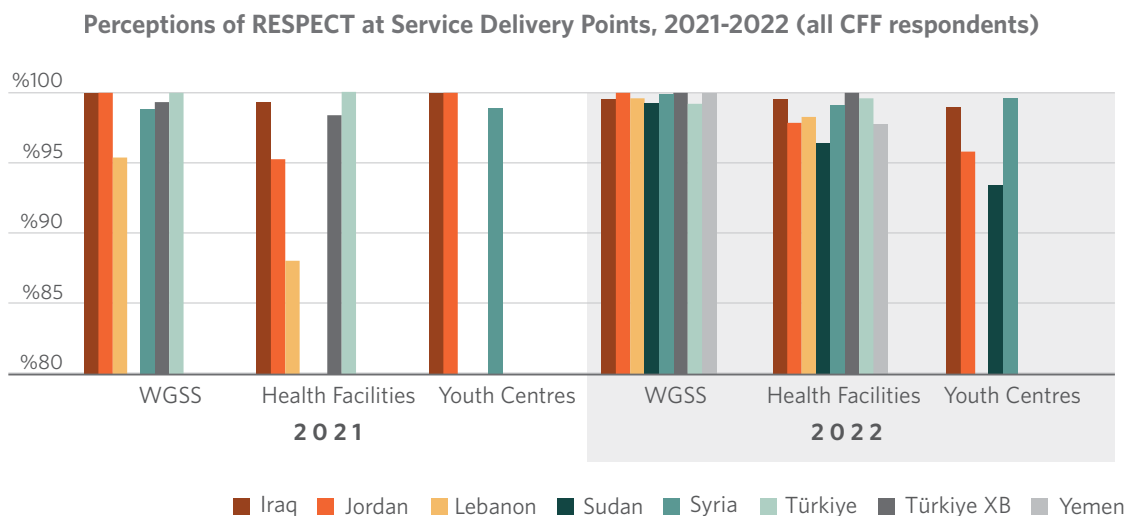
Perceptions of SDP Safety

Perceptions of safety amongst attendees at SDPs were, and remain, extremely high across all countries and services. For most, the high 90th percentiles of respondents considered the SDPs they attended to be safe. In some countries (**Iraq, Lebanon, Syria and Türkiye**) 100% of women and girls considered the Safe Spaces to be safe – an excellent achievement. Many others saw improvements from 2021 to 2022, although given the already-high level of safety only modest gains were seen.

Perception of Feeling Respected

Similarly, feelings of respect were consistently high in 2021, and retained or improved upon this rating in 2022, with some individual countries improving significantly (e.g. **Lebanon** health facilities improved from 88% in 2021 to 98% in 2022).

Figure 51: Perceptions of RESPECT at SDPs, 2021-2022 by Country and SDP

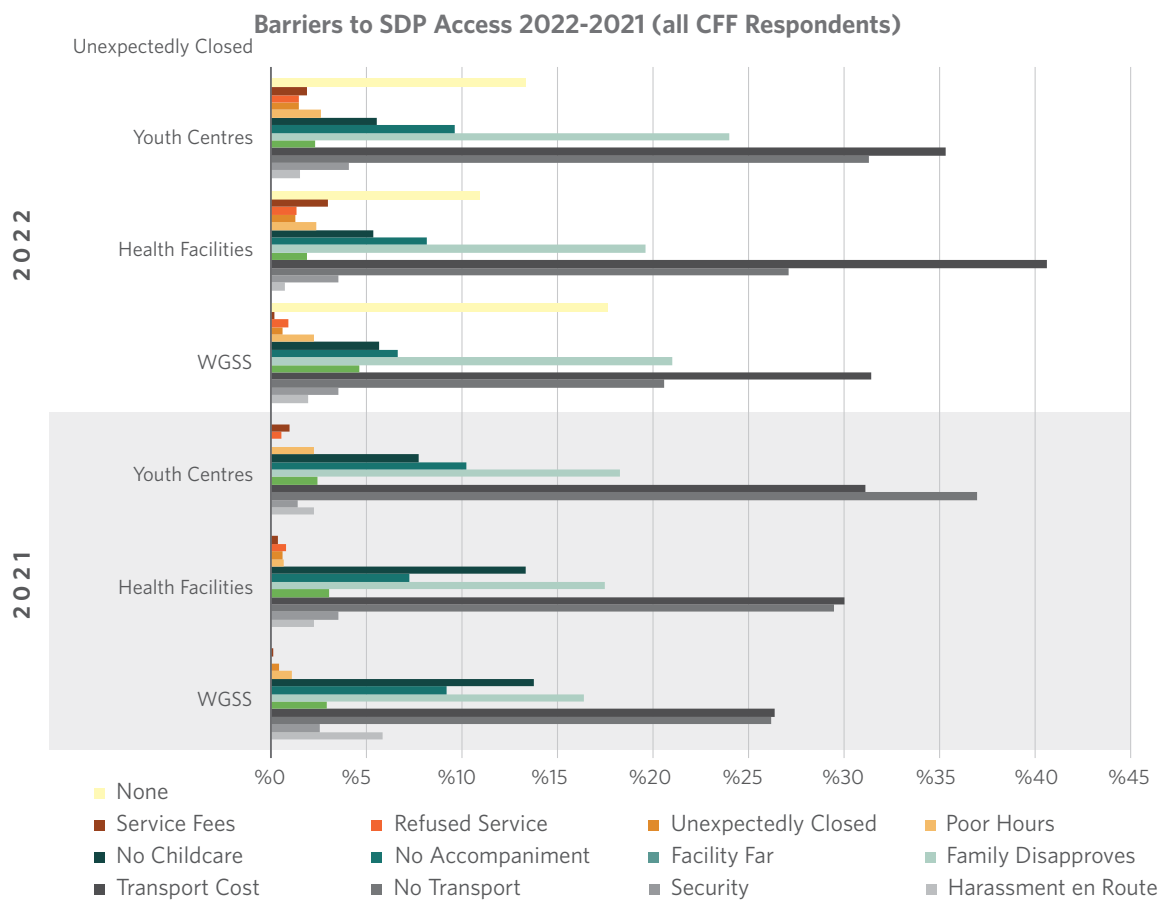


Dimension B (Access): The challenges in accessing these services

Comparisons of the different barriers faced by service users saw a consistent increase in the perception of transportation/logistics-related issues from 2021 to 2022. An additional 5%-10% of respondents identified transport costs as a key barrier between both years, with similar increases in the related barrier of facility distance.

On the positive side, other barriers such as presence of childcare, accompaniment and harassment en route all saw decreases, with the proportion of those experiencing no barriers increasing – not measured in 2021 – at an average of 14%, highest for Safe Spaces at 18%.

Figure 52: Barriers to SDP Access 2021-2022 by SDP



How Service Users Know of the Services

Between 2021 and 2022, the significance of word-of-mouth in disseminating information about the services supported by UNFPA has increased significantly for all SDPs, with relative decreases in other means (notably IEC activities and facility outreach). The use of social media was not covered by the 2021 assessment, but it is likely that it is taking the place of IEC and outreach. It is particularly popular amongst youth centre attendees.

Satisfaction with SDP Staff

In general (albeit with a limited sample of countries from 2021), overall satisfaction with the staff in facilities supported by UNFPA is high – over 95% for most. An exception is health facilities in **Lebanon**, which only had a 71% approval rating for 2021, but saw this increase to 93% in 2022. The only other country of note is **Sudan**, where satisfaction among youth centre staff was only 60%, but Sudan was not included in the 2021 assessment, so it remains to be seen whether this will improve in the year to come.

Figure 53: How Respondents Heard of Services 2021-2022 by SDP

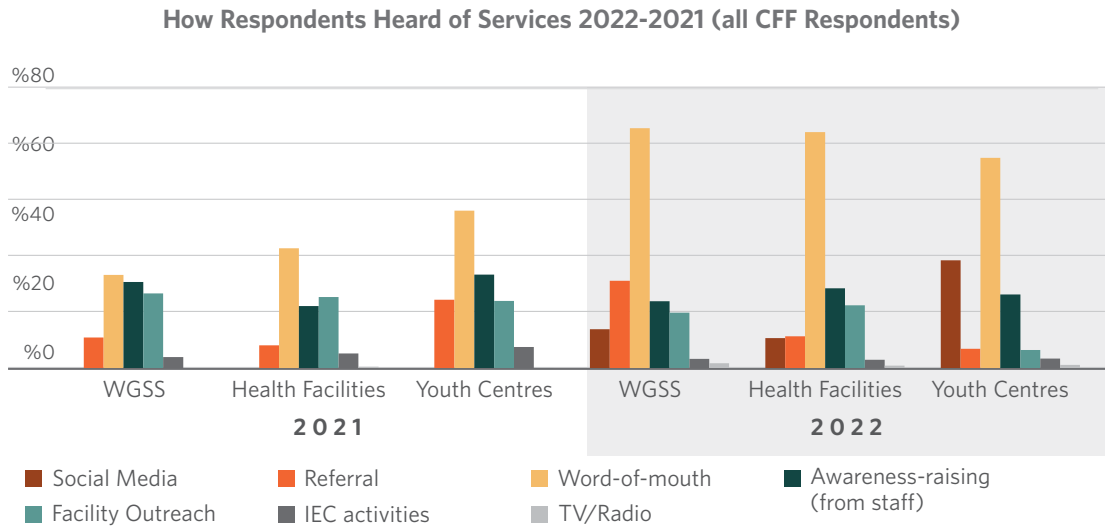
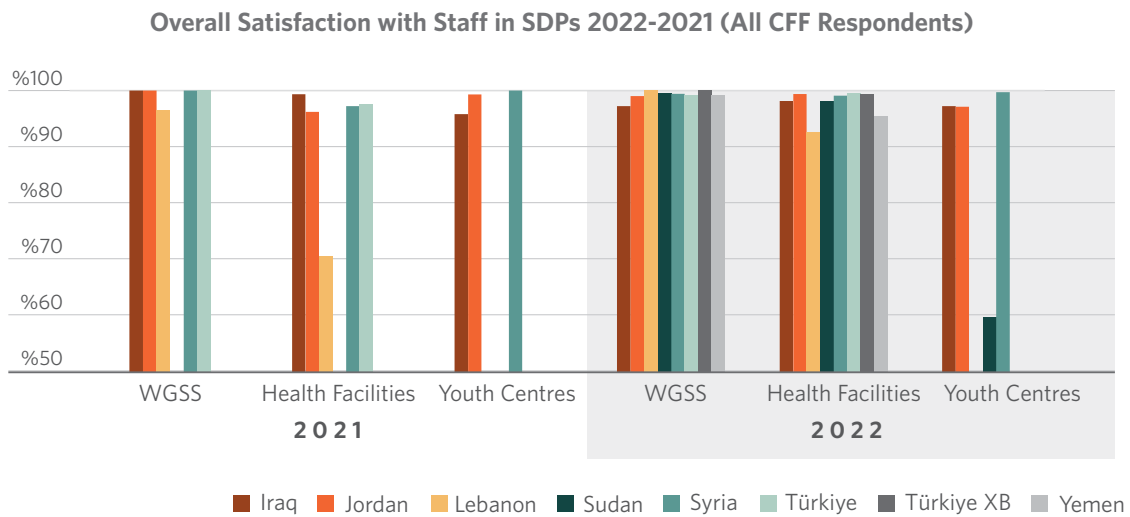


Figure 54: Overall Satisfaction with Staff in SDPs 2021-2022 by Country and SDP



DIMENSION E: Monitoring of recommendations from 2021

This section provides an update on the recommendations from the 2021 impact assessment. This assessment included the following recommendations and actions taken across the assessment countries (if available) to address them. Note that Sudan and Yemen were not part of the 2021 assessment so measures taken by them are not included.



RECOMMENDATION 1.

Roll out knowledge series on *Transcending Norms* and increase cross-country learning on gender transformative approaches, regularly providing examples from different countries

To address this recommendation, UNFPA **Iraq** in 2021/2022 undertook a country-wide study on attitudes of the Iraqi population around the subject areas of child marriage, FGM/C, sexual harassment, the role of men, and the role of women. Findings of the study primarily target policymakers, NGOs, and CSOs. Additionally, in 2022, UNFPA organised a National Conference on Early Marriage, from which 18 recommendations were proposed reflecting a consensus on reducing early marriage, and improving the health, educational, and social conditions of Iraqi families. UNFPA **Iraq** also is currently (mid-2022) developing a strategy and action plan to address gender stereotypes/harmful social norms and barriers to access/ utilisation of family planning, due for completion by the end of 2022.

In **Jordan**, UNFPA developed a toolkit entitled *Advancing Women's and Girls' Empowerment in Humanitarian Settings* to promote a new and enhanced perspective on, and relevant tools for, Safe Spaces management. UNFPA also conducted research on innovative partnership options, including with the private sector, to enhance access to gender transformative opportunities. Finally, UNFPA promoted gender transformation through promotion of traditionally male-dominated vocational activities (electricity/plumbing) via a range of Safe Spaces in 2021.

Through partnerships with different entities, UNFPA **Lebanon** implemented a series of community-related interventions in 2021/2022 with the aim of challenging existing social norms. Interventions included roundtables with community gatekeepers, syndicate members and religious leaders, as well as specific sensitisation programmes targeted at men and boys.

At the end of 2021, UNFPA **Syria** piloted a new project aiming at changing harmful social norms in Aleppo city. The project provides couples with a set of interactive training and take-home exercises designed to help foster a process of change to reduce intimate partner violence. The original curriculum was part of the *What Works to Prevent Violence Against Women and Girls* initiative, and the structure and content is built upon the latest learning from the Rwandan *Indashyikirwa* GBV prevention methodology.

Following the knowledge series on *Transcending Norms* good practices and recommendations, UNFPA **Türkiye** worked in 2021 and 2022 to strengthen capacities of implementing partner staff; revise/expand the Women and Health Counselling Centre SOP by adding detailed information on GBV case management services (and training case workers and psychologists on this revised SOP); monitoring Safe Spaces for application of the SOPs and the inter-agency *Minimum Standards for Gender-based Violence in Emergencies*.

UNFPA Türkiye and WFP established a collaboration agreement on the expansion of WFP's Livelihood project target to GBV survivors and LGBTQI community in 2022. As co-chair of the GBV sub-working group, UNFPA researched gaps faced by women and girls in getting access to services, resulting in a scale up of Turkish language courses and strengthened collaboration with Public Education Centres and mainstreamed discussions on gender norms in most trainings as well as adaptation of the AMAL (Adolescent Mothers Against All Odds) Initiative in the Türkiye context.

UNFPA Türkiye also launched a Menstrual Health Management assessment in 2021 to gain a better understanding on women, girls and LGBTQI individuals' access to menstrual hygiene products, to assess their menstrual sanitary practices and information on menstruation. The report findings will be used to amend the existing actions and to design new programs tailored to beneficiaries needs.

Through increased support to new Safe Spaces, UNFPA **Türkiye cross-border** programming significantly invested in expanding gender transformative interventions in 2021/2022, including innovative practices to enhance meaningful engagement of men and boys, as well as adolescent girls. UNFPA and its partners



used the *GBV Awareness Raising Toolkit*, developed by the GBV Sub-Cluster (SC) in 2018 and revised in 2022 based on lessons learnt and best practices.

Additionally, UNFPA continued to address discriminatory attitudes and stereotypes among adolescent girls through the *AMAL Initiative* that focuses on family planning, early marriage, dangers of early pregnancy, how to tailor services for adolescent girls, spacing pregnancies, and the risks of home pregnancies.

Finally, UNFPA **Türkiye cross-border** programming rolled out support to income generating activities with linkages to employment and earning capacity, and with a focus on vulnerable individuals – including survivors of violence, female-headed households, women with disabilities, and older women, amongst others. The support targeted innovative and non-stereotypical business projects such as a women's gym where self-defence classes for women were organised.

RECOMMENDATION 2.

The Hub to develop a short (2-page) briefing note on this impact assessment and funding status, for COs to use for fundraising purposes.

In 2022, the Amman, Jordan Hub produced the *Funding Overview*¹⁶ which includes the funding status of each Syrian response country, as well as a short fact sheet¹⁷ for the impact assessment. These have been shared with donors, and the funding overview, which has a separate page for each country, has been used to mobilise resources.

RECOMMENDATION 3.

COs should consider reviewing their AAP plans and build capacity of service providers on provision of information to all beneficiaries with regard to confidentiality protocols, while incorporating feedback loops within AAPs.

Throughout 2021/2022, UNFPA **Iraq** closely coordinated with OCHA to address its AAP approach. UNFPA also implemented annual plans for capacity building of its partners and service providers in particular in terms of disability inclusion and beneficiary feedback solicitation and follow-up.

In **Jordan**, UNFPA reviewed the partner work plans to ensure inclusion and reporting of AAP indicators in 2022. Additionally, a field assessment was conducted on feedback channels, with partners subsequently reviewing SOPs to ensure capturing of relevant feedback in conformity with confidentiality principles.

For UNFPA **Lebanon**, This is yet to be initiated. This has been taken into consideration in the new Country Programme Document (CPD) which was being drafted in mid-2022.

UNFPA **Syria**, established an internal AAP task force in 2022 that worked on initiating a pilot project for AAP/feedback mechanisms in 2022 that assessed AAP capacities of IPs, scanned existing mechanisms and identified beneficiary preferences and concerns about feedback channels. In March 2022, the taskforce conducted a workshop for staff from the three partners. UNFPA is following up closely with partners through the AAP task force and focal points to ensure the implementation as planned and provide any technical support as needed. The implementation period is between June and Dec 2022. It is planned

¹⁶ <https://www.unfpa.org/resources/syria-crisis-overview-funding-needs-2022>

¹⁷ <https://arabstates.unfpa.org/en/publications/bridges-hope-key-findings-regional-impact-assessment-unfpas-syria-response-2021>



to have a review meeting at the end of the pilot to share experiences, with lessons learned to inform the expansion in 2023.

UNFPA **Türkiye** provided AAP sensitisation and information provision about complaint and feedback mechanism to all staff including SIDA-supported WHCCs in 2022, developed a standardised complaint and feedback mechanism, AAP SOPs for all Safe Spaces, integrated feedback mechanisms into the UNFPA online data collection system and plans to conduct training of partners to strengthen accountability. UNFPA **Türkiye** also prepared AAP materials in different languages to support the use of all complaint and feedback mechanisms, conducted monitoring of feedback and drafted follow-up/response actions.

UNFPA **Türkiye cross-border programming** continues to ensure that all supported facilities have a diverse set of feedback and complaint mechanisms which is available and accessible to all groups, including illiterate people and PWDs. TPM findings confirmed that accountability mechanisms were verified to be available in each facility and centre visited. Feedback mechanisms were advertised through appropriate messaging and diverse channels. The solicited feedback has been

subsequently addressed by IPs, and programming has been adapted accordingly when necessary. This process has continued to strengthen UNFPA's AAP approach.

To enhance its AAP's approach in 2022, UNFPA joined the newly-established *Change Taskforce* interagency forum, led by OCHA, which was set up to ensure AAP is integrated across cluster coordination mechanisms and within the Humanitarian Liaison Group. UNFPA supports the implementation of Action 9 aimed at prioritising gender equality and ensuring a good gender balance in all humanitarian and coordination meetings.

RECOMMENDATION 4.

For SRH in particular: Consider conducting research to understand the barriers to PNC in order to develop a regional campaign, particularly linking PNC as an entry point to family planning, as well as investigating the creation of incentives.

In **Iraq**, no research was conducted on PNC in 2022 as the UNFPA core programme focuses on family planning – a baseline survey on caesarean section prevalence, family planning, child marriage, mapping of private clinics and pharmacies is instead planned for 2022/2023.

As part of UNFPA **Jordan's** support to Lazord Fellowship, the CO supported a study of the quality of ANC and PNC services for Syrian refugee women in Za'atari Camp.

For UNFPA **Lebanon**, this has not been achieved yet, although PNC visits are now being treated as a priority across SRH programme planning.

UNFPA **Syria** has been undertaking preparations for a new CPD study in collaboration with the MOH to estimate the prevalence of unmet needs for family planning in Syria from late 2022 to mid-2023. UNFPA also supported the Syrian MOH to carry out research on quality of SRH services nationwide in 2021, albeit with some delays due to the ongoing impact of COVID-19.

UNFPA **Türkiye** will start working on understanding the barriers to PNC with the support of a SRH consultant in late 2022.

To foster understanding of barriers experienced by beneficiaries while accessing SRH services during COVID-19, UNFPA **Türkiye cross-border programming** conducted a study to assess beneficiaries' experience of online SRH consultations. Additionally, a UNFPA partner initiated a pilot initiative in 2022 targeting birth mothers with CVA. The financial assistance aims at enhancing PNC uptake and reducing financial barriers to access health care in a dignified and safe manner.



RECOMMENDATION 5.

In line with the upcoming UNFPA SRH/GBV Toolkit, consider strengthening referrals from health/SRHR services to other services like GBV within the continued effort to improve SRHR-GBV integrated services and approaches.

UNFPA **Iraq** established two One Stop Assistance Centres in 2021 that provide comprehensive services and support to survivors of GBV. These services include medical, psychological, and social services, protection, and legal counselling. UNFPA also worked with sister UN agencies and organisations on a referral mechanism to ensure survivors are getting needed services. UNFPA **Iraq** also integrated RHR-GBV integrated services within primary healthcare centres mainly in the south region to ease access to comprehensive services.

UNFPA **Jordan** undertook a range of safe referral training in 2021/2022 that led to an increased number of awareness sessions on GBV within clinics.

Under a SIDA funded project, UNFPA **Lebanon** has created linkages between SRH and GBV actors to ensure provision of GBV/RH integrated services. To enhance accountability, data systems and MEAL (monitoring, evaluation, accountability, and learning) processes have been refined to track referrals in a more efficient manner.

UNFPA **Syria** developed the current referral mechanism which is active in 10 governorates including SRH and protection services (including GBV).

UNFPA **Türkiye** has ensured SRH and GBV services are integrated in all supported WHCCs. Staff of centres organise regular meetings where they discuss internal coordination and the reporting process in the online data collection system which allows staff to tag each other (referrals) when cases are referred within the centre.

In April 2022, the GBV sub-cluster and the SRH technical working group for **Türkiye cross-border programming** launched a joint initiative aimed at integration of GBV services into health facilities in NWS. UNFPA, with support from the WHO, completed a baseline study to evaluate the level of integration of GBV services in EmONC facilities and make recommendations on GBV and PSEA. The GBV SC and the SRH TWG are currently addressing the findings that have emerged from this study ensuring that GBV risk mitigation measures are mainstreamed in all health facilities. In this framework, updated trainings on CMR and case management were organised in 2022. Additionally, in the framework of this initiative, a community-based study was completed on “Barriers to women and girls, especially GBV Survivors, Accessing Proper Reproductive Health Services” in NWS. This study will aid humanitarian responders to better plan and



improve programs – in consultation with the communities served – and to increase the availability, accessibility and acceptability of SRH and GBV services and information. Particular attention will be paid to adolescent girls who often face barriers to these lifesaving interventions.

RECOMMENDATION 6.

Following on from the 2020 recommendation: ensure that outreach and awareness raising of services (marketing) is distinct from awareness-raising programming i.e. awareness raising of rights and gender issues.

UNFPA **Iraq** has worked on differentiating the awareness raising around services from awareness-raising programming on rights and gender issues through developing visibility/IEC materials and supporting events/campaigns to promote and market UNFPA work. UNFPA also continued working with partners and building their capacity to ensure communities are sensitised on GBV, human rights etc.

UNFPA **Jordan** partners conducted a range of outreach activities on services availability and awareness on rights, gender, and GBV throughout 2021/2022

In **Lebanon**, marketing or awareness generation regarding the UNFPA-supported programmes is separate to SRH/GBV content oriented awareness sessions as per programme design.

Starting from May 2021, UNFPA **Syria** designed an information dissemination exercise aiming at providing information on GBV/SRH services to affected populations in line with awareness-raising sessions focusing on GBV and SRH. UNFPA provides ongoing support to partners via guidelines and reporting tools. As of November 2022, a primary prevention consultant will be revisiting the exercise as part of the GBV prevention strategy, and will provide the needed guidance to enhance this activity.

For UNFPA **Türkiye**, outreach work and awareness raising on services, as well as sharing basic information on rights and gender, is carried out by outreach workers (health mediators). Awareness-raising activities on rights and services are implemented by the trained service providers. UNFPA Türkiye has a standard set of sessions/presentations shared with the service providers specific to their roles such as SRH, GBV, women's empowerment and they were then trained on how to deliver these sessions.

In 2022, UNFPA Türkiye revised the WHCC SOPs and expanded its content by adding detailed information about staff roles and responsibilities, GBV case management services, and accountability to affected communities, amongst others. All case workers and psychologists were trained on the revised SOP. Health mediators (outreach workers) received training and refreshment sessions on their roles and responsibilities. Regular supervision sessions are organised with health mediators as well as their supervisors.

UNFPA **Türkiye cross-border programming** partners ensured that outreach and awareness raising around services is distinct from awareness-raising programming throughout 2021/2022. For targeted awareness-raising programming, UNFPA partners used the GBV sub-cluster-developed *Awareness Raising Toolkit* which provides four comprehensive programs for raising awareness around seven key GBV messages to women, adolescent girls, men, and adolescent boys.

RECOMMENDATION 7.

For working with adolescent girls, and ensuring accessibility for people with disabilities, UNFPA should continue to keep this focus and work on the trajectory of continued improvement in these areas across all countries.

UNFPA **Iraq** has a dedicated *Adolescent Girls Toolkit* and chairs the Adolescent Girls Task Force for **Iraq**. In 2021 UNFPA renovated GBV facilities to make them more disability-friendly and accessible to women and girls. UNFPA also supported capacity-building training on the inclusion of PWD and girls with disabilities. Further, via the Task Force, UNFPA supported training on inclusion of girls with disabilities in services and programming and also supported integrated services/facilities for PWD.

In 2021, UNFPA **Jordan** invested in tailored adolescent girls programming in Safe Spaces, including hiring an adolescent girl officer to oversee the AMAL approach in Madaba and the recently open adolescent girl-led centre in Za'atari camp, as well as the Adolescent Girl Asset Framework in KARAK. On disability inclusion, 845 women and girls with disabilities were reached through awareness, recreational and empowerment activities (an increase of 16% from 2020/2021). This was achieved through investing in capacity building of project staff and service providers on GBV and PWD and strengthening outreach and partnership with local organisations working with PWD for safe referrals and tracked results in the work plans to enhance accountability. In addition, in collaboration with the Higher Council for Persons with Disabilities an assessment of Safe Spaces in Irbid was conducted which recommended improvements on centre accessibility for women and girls with disabilities.

PWD are targeted by UNFPA in **Lebanon** through outreach activities. Partners are requested to report on the number of beneficiaries with disabilities reached under the GBV programme. UNFPA completed an analysis and mapping of GBV against women and girls with disabilities in mid-2022. UNFPA plans to leverage the findings to improve services and make programmes more inclusive. UNFPA **Jordan** is also regularly tracking vulnerability specific data and encouraging partners to focus on outreach to the marginalised, such as adolescent girls, PWDs and older women.

Adolescent girls and PWD reached by UNFPA **Syria** programmes through different interventions:

- Adopting and adapting the Girls Shine manual to pilot it in Al Qusair (Homs).
- Training on braille and sign language under the youth programme (resilience).
- Young girls targeted with awareness raising on MHM and other RH and GBV information.
- Interventions at the Institute for People with Disabilities including training on design and implementation of community-based initiatives.
- Adolescent girls are targeted with all the youth programme interventions including awareness raising, capacity building, PSS services, robotics, etc.
- A specific indicator in each annual work plan on inclusion of young people with disabilities.
- Training of family medicine doctors and midwives on Comprehensive Sexual Education, the information of which can be disseminated to adolescent clients.

For UNFPA **Türkiye**, examples of programming for adolescent girls and people with disabilities are:

- An assessment in the context of youth programming, to be finalised by the end of 2022 that identifies SRH, GBV and empowerment needs of the refugee adolescent girls.
- Selected Safe Spaces have been organising a series of specialised sessions on puberty for adolescent girls, via nurses/midwives and psychologists.
- Adoption of the AMAL initiative. For 2022, the content is under review to identify the relevant parts for the **Türkiye** context.
- Safe Spaces have started reaching out to the women and girls with different types of disabilities, organising group awareness sessions, and providing information on GBV and SRH.
- UNFPA and implementing partner ASAM implemented a project for RWD through two specialised service units.
- Safe Space accessibility has been developed further, including the presence of accessible toilets, ramps and wider waiting areas.

- UNFPA developed information videos on gender equality, GBV and family planning, which allows PWD to follow the content through sign language and lip reading. There are also brochures in Braille and larger fonts on CEFM, hygiene and GBV.

UNFPA **Türkiye cross-border programming** continued to implement multiple initiatives targeting adolescent girls. The AMAL initiative continued to produce positive impacts on the lives of pregnant adolescents and first-time mothers through the *Young Mothers' Clubs*, community leaders who were part of the community engagement activities, and health service providers who were engaged in transformational activities aimed at shifting their attitudes and biases toward providing SRH services, including family planning, to adolescents.

Further, a UNFPA partner implemented an initiative entitled *Rebel Girls*, co-designed by the Amman Hub. Additionally, UNFPA's partners ensure that all supported facilities are accessible to all groups by building wheelchair ramps, installing handrails, and modifying accessible toilets. One partner increased accessibility by building an elevator in its newly constructed health facility. The use of mobile clinics have been critical to provide medical services directly at beneficiaries' homes. All staff are trained on specific barriers faced by women with disabilities while accessing essential services.

RECOMMENDATION 8.

Hub should consider developing a guide for how to increase access to LGBTQI populations based on the efforts from Jordan and Lebanon, slowly and carefully.

A knowledge product has been developed by the Amman Hub on programming with LGBTQI populations. Further, a consultant was hired in 2022 to conduct consultations with key actors from **Lebanon, Jordan and Türkiye** UNFPA COs on their LGBTQI programming and compile a desk review of key documents shared by these three COs.



RECOMMENDATION 9.

UNFPA should regionally consider guidance on how to view transportation barriers as more of an issue under UNFPA's control (while recognising it as an external issue). UNFPA should also use current innovations across the region to provide practical examples and support on how to prioritise either the services being accessed or the groups accessing (PWD, adolescent girls etc.) so that countries can then decide what works best in their contexts.

UNFPA **Iraq** contributed to its *Advocacy Brief* by clarifying the added value of transportation to access Safe Spaces and health facilities that were initiated by the Syria Hub. UNFPA **Iraq** has started working with partners to put in place a mechanism to ensure that transportation barriers are addressed and supports partners to provide transportation for cases when referral to other services between districts or governorates is needed. In a 2022 pilot project on providing livelihood opportunities to women and girls, UNFPA worked on providing either transportation fees to beneficiaries or hiring buses to ease access to the services.

UNFPA **Jordan** uses emergency cash assistance to address barriers to accessing services and organises transportation for some specific initiatives (e.g. a gender digital divide project with the ZAIN telecommunications company).

UNFPA **Lebanon** piloted a six-month project on Telehealth where vulnerable beneficiaries in need of SRH services were referred to medical care through phone consultation. Follow up by social workers ensured

support in referral to health facilities for beneficiaries in need for tests/additional care. An evaluation of this pilot initiative in 2022 attested to its added value in addressing transportation barriers. This was addressed by providing *Cash for Transport* via the UNFPA Lebanon CVA programme. The number of mobile units also saw an increase in 2022 to ensure outreach at the community level.

In **Syria** in early/mid 2021, UNFPA launched the *Female Driver Project* that uses a female driver to bring female beneficiaries from rural and remote areas to the UNFPA-supported service facilities in Deir-ez-Zor Governorate. UNFPA mobile teams worked to build trust with beneficiaries, educate them on the purpose of the intervention and measure the community understanding and acceptance of transporting women to the UNFPA-supported facilities using a female driver. Advocacy at government level was essential to gain official support, secure help if needed from police/security and facilitate the process. This project ensures safe and secured access to SRH and GBV services for women in remote and isolated areas, introduces a female driver as a role model to challenge social norms and serves as a vehicle for GBV and SRH messaging (for which the driver is trained).

Upholding the principle of 'Leaving No One Behind', UNFPA **Türkiye cross-border programming** partners worked to ensure that GBV and SRH services are available for and accessible to women and girls with special needs, such as PWDs, older women and women living in hard-to-reach areas. Specific efforts have been made to improve the accessibility of the facilities, for instance by providing free transportation to all for Safe Spaces and transportation for vulnerable groups to health facilities. As confirmed by TPM findings, this service has been widely promoted both within the facilities and during outreach efforts throughout 2021 and 2022.

RECOMMENDATION 10.

Build on the experience of integrating CVA within GBV and SRH programming to reach scale and replicate good practices in the region. UNFPA should consider conducting research on integrating CVA within the case management process with Johns Hopkins University and set up strong monitoring systems.

Two researches were conducted in partnership with JHU in 2021/2022:

- A comparative analysis between dignity kits and Individual Protection Assistance in **Türkiye cross-border programming**;
- Publication of a study "From Risk to Choice: Cash Within GBV Case Management" in **Jordan** (September 2022).

Further, monitoring systems on cash were established in **Jordan** and **Lebanon**. A regional monitoring framework is under finalisation and roll out is planned for 2022.



Section 3.

Regional

Conclusions and

Recommendations

Section 3. Regional Conclusions and Recommendations

OVERALL SUMMARISING CONCLUSION

The outcomes of a range of different crises around the world have thrown into sharp relief the value of the work that UNFPA has supported across its mandate areas in the past year.

Firstly, the diminished, but ongoing, impact of the upheavals caused by COVID-19 have highlighted the huge value that UNFPA brings to the health and wellbeing of women, girls and young people across the countries where it works. The often challenging-to-measure benefits of Safe Spaces and youth centres on mental health and psychosocial wellbeing have been underscored by the many people that report having struggled through lockdowns and service restrictions. The reopening of services has been widely welcomed, and despite a legacy of negative outcomes on SRH and wellbeing resulting from the pandemic, there is good consensus that where UNFPA support has been in place, positive progress has been sustained.

Secondly, the slow but progressively more challenging macroeconomic crisis that has been experienced by most countries is eroding the resilience of rights-holders. Broad-based increases in the cost of living for all mean that the no-or-low-cost SRHR, GBV and youth services and commodities provided by UNFPA are increasingly in demand, as well as increasing the need for ways to improve the accessibility of services. In tandem with this is the increasing popularity of services that help women and girls to find ways to generate their own income to mitigate increasing economic hardship, but also a sign of increasing empowerment and changing gender norms.

Thirdly, increasing economic headwinds and the conflict in Ukraine are constraining availability of humanitarian funding and resources that UNFPA and its constituents rely upon. Actors are tasked more and more to make difficult choices on what programming to prioritise and to increasingly do more with less. This has spurred innovative approaches to outreach and training (e.g. linking vocational training or education in centres to formal certification), and a drive to sustainability via a transition of humanitarian programming to longer-term peacebuilding and development modalities, as well as examples of programming handover to national actors (for example in **Türkiye** and **Iraq**).



Dimension A: Wellbeing

- **PSS, social, recreational** and **vocational training** activities are the most **impactful and favoured** within the Safe Spaces and youth centres that UNFPA supports. Among users of health facilities, the increasing economic challenges that people face mean that a wide range of general health services are solicited and wanted at health facilities, but **SRHR** and **ANC/PNC** services are still viewed as the most important services that are provided.
- **Changes to services** that users would like to see at Safe Spaces and youth centres are mostly in the areas of **vocational training, education** and **social/cultural activities**, in line with the most popular existing services. Again, the economic challenges faced by many mean that opportunities to build marketable skills that can be used for employment or generate income are becoming increasingly important – a driver of positive changes in gender norms. At health facilities, there are ongoing demands

for **general medical care, ANC/PNC/Infant care and medication provision**, not all of which are within the UNFPA mandate.

- **Commodities and dignity kits** are having an increasing impact on women's wellbeing as socio-economic conditions deteriorate in most countries – everything has a use, with the main user criticism that more are needed. Organisationally, there are ongoing challenges in logistics and procurement as a legacy of the disruptions of COVID. These are seen both internationally in terms of procurement by UNFPA and also in some countries (e.g. **Sudan**) with respect to national logistics systems and last mile distribution. Shortcomings in the resilience of procurement and logistics systems came to the forefront during COVID-19 and are not yet resolved. A concern that should be noted is around the increased demands for kit contents on their own diminishing the value of kits as entry points for important IEC messaging. While CVA is increasingly popular, there is still a role for kits within programming and where markets local markets may not have important hygiene items in resource-poor settings

“The kits are a good entry point for services, but the cash is a very dignified approach.”

– (UNFPA CO, Syria)

- There is **high trust, confidence and perceptions of respect** in the facilities and services that UNFPA supports, a dividend sustained from year to year. Nonetheless, feedback mechanisms remain an area of deficit, something that has been noted in previous years, although the inclusion of Yemen and Sudan in the assessment for this year have skewed results somewhat.
- There is good evidence that UNFPA-supported services are contributing to the three transformational results that UNFPA is seeking to achieve:
 - **SRH**: The assessment has found consistent (albeit anecdotal/qualitative) evidence that UNFPA-supported services are mitigating challenges to maternal/neonatal mortality/morbidity, although hard data is not tracked in many countries.
 - **GBV**: Many stakeholders report positive impacts on women's empowerment and psychosocial wellbeing, with movement in gender norms and socio-economic outcomes for women's livelihoods an unexpected dividend of challenging economic environments.
 - **Youth**: Socialisation and vocational training are the key services offered by youth centres, which are a key point of contact with youth that might otherwise have no access to information. An interesting return on investments in online modalities due to COVID has been the value of online access for more vulnerable youth that might otherwise not have access to youth centres. Other (non-centre-based) youth activities in education, SRH, GBV are also showing good outcomes where in place, underscoring progress on UNFPA commitments to the youth, peace and security agenda.

Dimension B: Access

- UNFPA still plays an irreplaceable role in supporting life-saving services, particularly for GBV, where there are few, if any, other options for women and girls to receive assistance. For SRH services, while many countries have public services as a complement to, or that are supported by, UNFPA, most are seeing significant increases in demand for lower-or-no-cost public services. Limitations on funding and a shortfall of medical specialists mean that the SRH needs being served by UNFPA are ever more crucial. In some countries and locations, lack of UNFPA support for SRH services means immediate increases in maternal and neonatal mortality and morbidity. In some countries (e.g. Iraq, Türkiye), UNFPA is working on exit/sustainability strategies, but there are significant concerns around the quality of care, particularly for women, girls and neonates, with funding constraints likely to impact even more significantly in 2023.
- The biggest challenges identified across all assessment countries were related to **transportation – cost, lack of transport, facility distances** and the **impact of extreme or adverse weather/climate**. This continues the trend seen in the 2020/2021 assessment. While some service users found ways around the transportation challenges, the provision of mobile/outreach services that can reach remote areas and/or subsidised transport to facilities has proven increasingly popular. Most countries have worked to incorporate additional measures on facilitating transportation for attendees (per the recommendation from 2021), but the significant increases in fuel costs seen in 2022 (and knock-on impacts on a wide range of utilities and commodities) have exacerbated this trend.



- Measures for and challenges to **access of vulnerable users** to services centre primarily around improving accessibility for PWD, adolescents, widows/elderly. While most measures are geared towards reducing physical barriers to facility access, there are a range of actions reported by most participating countries for other disabilities (e.g. cognitive, visual, auditory) which are often not given the required attention. Given the high proportion of disability reported by women and girls attending UNFPA-supported facilities, particular attention to disability in all its forms is well warranted. There is also a good continuum of focus on LGBTQI community members from last year to this year. The positive examples of work with this community in Jordan, Lebanon, Sudan and Türkiye are important, particularly as the risks to LGBTQI community members increase in response to socio-economic challenges. The measured expansion of work in this area by UNFPA could present useful opportunities for cross-country learning.

- The legacy of the **COVID-19 pandemic** is still being felt across countries, particularly with respect to the stress and other health impacts of the crisis.

Stakeholders widely acknowledged that restrictions on availability of SRH care are likely having impacts on health metrics, and UNFPA should be ready to incorporate these into results targets and work plans. Although 2021/2022 saw conditions largely revert to normal, all UNFPA operations are implementing at least some precautions and COs are comfortable with training/SOPs if another wave manifests (or a different crisis materialises). However, complacency may be a concern – although immunity is high across populations, many precautions are now forgotten, and issues of vaccine hesitancy may present additional complications. It will be important for UNFPA and partners not to capitalise on lessons learned and good practices from the changes wrought by the pandemic. In this regard, the system-wide global COVID-19 evaluation and the global UNFPA resilience evaluation, both planned for publication in 2023, may present useful recommendations for action in terms of sustainable measures and resilience/preparedness actions.

- The use of **CVA** is becoming increasingly popular across the region, with an increasingly robust body of learning and evidence to support its utility and effectiveness, especially the use of emergency cash to help survivors of GBV and potentially for income-generating activities. Most UNFPA COs have built (or are building) expertise in this modality and there are definite opportunities for scale-up, if resources permit. An expanding programme of CVA in Syria implemented by UNFPA and WFP is showing good progress in both providing much-needed support and linking it successfully to provision of SRH and GBV information, a model that may warrant further assessment, documenting and potentially scaling-up/replication.

Dimension C: Efficiency

- **Human resource needs** are varied. Typically, GBV and youth services are well-staffed, albeit through considerable use of volunteers. There is, however, a shortage of health specialists across the board. Key challenges in recruiting and retaining health specialists are around lack of resources, insecurity of tenure and “brain drain” from crisis locations. The economic challenges facing countries is resulting in a movement from public sector facilities to the private sector.
- There is an ongoing substantial appetite for **training across all sectors**, although the perception from many partners and community members is that online offerings are at saturation and there is considerable appetite to go back to in-person modalities. Despite the legacy of pandemic restrictions, UNFPA has supported or conducted a wide range of training across all sectors over the course of the year, with plans for more. Service users are almost unanimously happy with GBV service provider staff capacity, although some noted issues with health facility and youth centres staff – potentially ongoing reviews of skills and accountability measures are required.

- Most stakeholders are satisfied with the **facilities and commodities**, although a range of challenges related to equipment, pipelines and increasing costs are emerging. This is particularly notable with respect to **RH kits**, for which there is ongoing and sustained demand, but there are a variety of pipeline, clearance and/or last mile distribution challenges. Some of these are an outcome of the COVID restrictions, which imposed huge demands for commodities on UNFPA procurement pipelines, and some are due to the economic crisis, which have resulted in substantially increased logistics costs. Other challenges are inherent to fragile national systems, which have not been able to manage the various crises in maintaining or supporting commodity pipelines at national and sub-national level. The weakness or instability of such systems is an important issue for UNFPA, not just for the present, but potentially in the coming years as the effects of challenges such as climate change need to be negotiated.

Recommendations

1. **GBV/Youth:** Review **AAP plans and feedback/response mechanisms** within SDPs, particularly Safe Spaces and youth centres with a view to:
 - a. Ensuring activities offered at the SDPs are in line with peoples' abilities/capacities, including age-and-ability/disability-appropriateness.
 - b. Ensuring vocational training activities are suited to the economic environment and the wants/needs of the participants to create/support livelihoods opportunities where possible.
 - c. Emphasising existing feedback processes so participants understand that their voices are being heard and acted upon to the extent possible.
 - d. Linking to CVA assistance (in line with the emerging body of practice and expertise within UNFPA) that can complement other programming modalities as an entry point as well as standalone assistance.
 - e. UNFPA is developing improved global guidance on AAP for rollout in 2023 which should be integrated into UNFPA humanitarian programming to ensure commitments to the Grand Bargain are sustained.
2. **Youth programming:** UNFPA Humanitarian programming is disproportionately focused on GBV and SRHR versus youth – only four of the eight operations under review had facility-based support (though some other youth initiatives were supported in other countries). UNFPA should deepen its engagement on youth to fulfil its commitments under the UNSCR 2250 youth, peace and security agenda and mitigate GBV and negative SRHR outcomes.



THE KITS ARE A GOOD ENTRY POINT FOR SERVICES, BUT THE CASH IS A VERY DIGNIFIED APPROACH.

— (UNFPA CO, SYRIA)

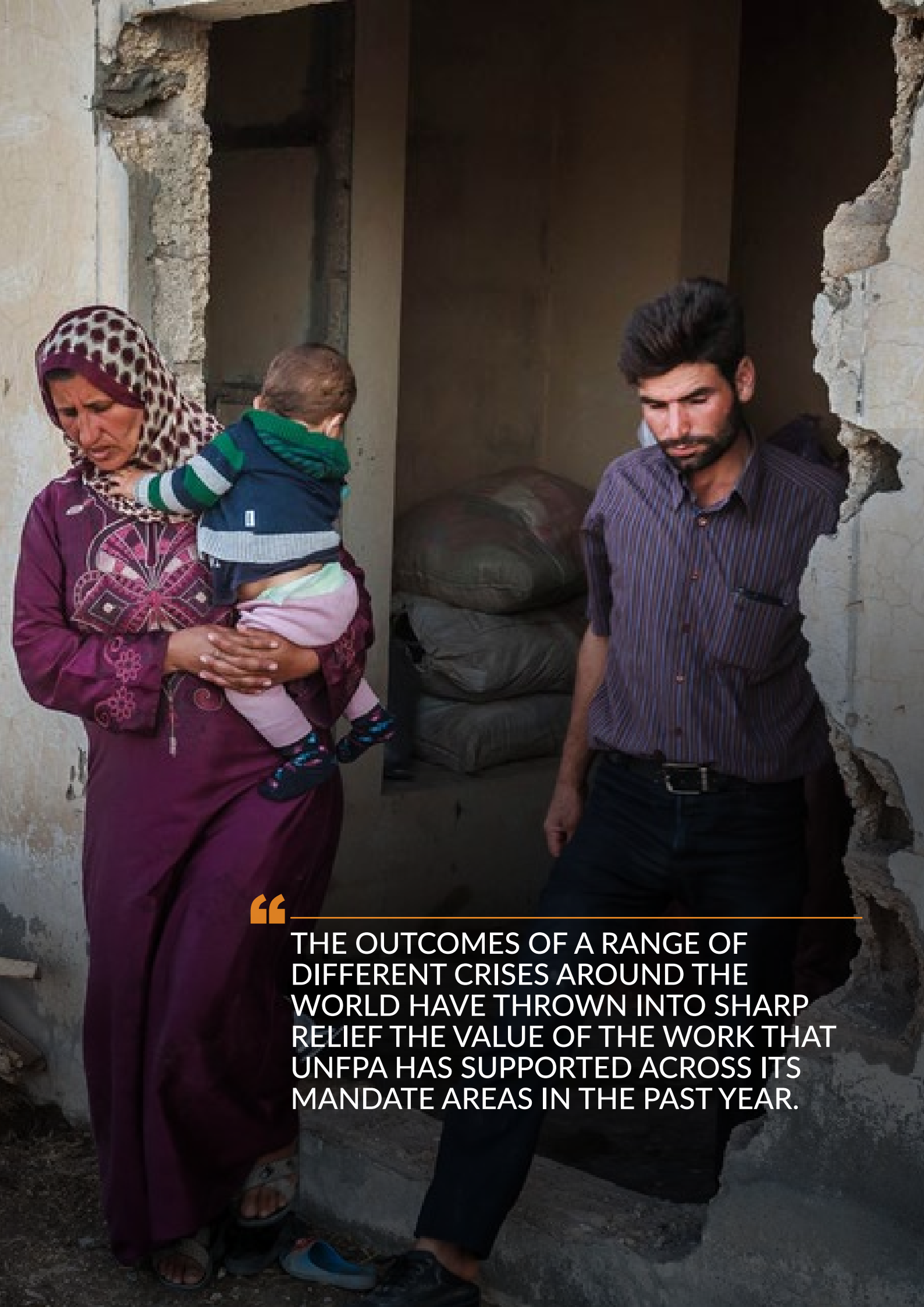


3. **Redouble focus on access of vulnerable groups** to all services – not just people with physical disabilities, but those with less visible disability, and groups that may not be able to access services for other reasons – gatekeeping (adolescent girls) or prejudice (LGBTQI). Learn from the prudent and cautious approach from countries such as Lebanon and Türkiye to develop and implement strategies that will not increase risks to programming and rights-holders in countries where significant prejudice and/or legal restrictions exist for LGBTQI communities. Use of the Amman Hub knowledge series on how to replicate the good practices relating to LGBTQI work in Jordan, Lebanon and Turkey could be a key driver of work in this area in 2023.
4. **SRHR:** Manage increasingly scarce funding to build capacity of facilities to attract and retain specialist medical staff by recognising and addressing the challenges that drive staff attrition. Build on good practices in some countries (e.g. Türkiye, Lebanon) to create and manage opportunities to integrate work with other SDPs (GBV/Youth) for SRHR information and referrals to services and/or government services to building sustainability of SDPs along the Humanitarian-Development-Peace nexus. The forthcoming guidance toolkit on SRH/GBV integration should provide direction that can be adapted for individual country contexts.
5. **COVID-19:** Situations are reverting to business-as-usual across most countries, but pandemic risk is still an issue. Ensure appropriate in-country preparations and resilience (as well as combatting complacency and vaccine hesitancy). Global evaluations of UNFPA COVID-19 response and resilience is due in 2023, so learning from this may be useful, as could be other forthcoming guidance that seeks to learn the lessons of the pandemic, e.g. the *Adapting to the New Normal* guidance note to be published by the Amman Hub in 2023 – which looks at how countries have adapted to COVID-19. Dissemination of this resource across the region (and beyond) will be an important step.
6. Identify and sustain the good practices developed as a result of COVID-19 mitigation strategies, particularly around **telehealth/online GBV/youth services**. Leverage normalisation of online usage, remote work to building on improved remote infrastructure, not just health, but also GBV and youth work. Assist vulnerable young people, particularly adolescent girls, to address service access issues by moving online and ensure a useful new avenue for information. Create safeguards to minimise the risk of online modalities being an avenue for misinformation and abuse (e.g. cyber-bullying or other online exploitation) and assess the outcomes/impacts of misinformation on the accessing of UNFPA-supported services, especially GBV interventions, by women and girls.



7. To ensure continuity of programming and build programmatic resilience, strategise on mitigation strategies for procurement, distribution and management of **commodities** (both dignity/hygiene kits and RH kits). The legacy impact of COVID-19 on supply chains and logistics is exacerbated by increased need due to economic crises which are having a direct and indirect impact due to lack of services and supplies. In an environment of increasing deprivation, redouble efforts to ensure that the distribution of commodities (and any associated messaging/IEC) are appropriately targeted at the most vulnerable. Further, the importance of dignity/hygiene kits for provision of increasingly hard-to-afford essential items and valuable entry-points for other programming means they should be mainstreamed across programming wherever possible, including those countries that have not distributed kits in the past year or longer.
8. **Acute & long-term crises:** Economic hardship and climate change are hitting all countries. Maintain and redouble focus more on practical/efficient solutions – livelihoods linkages, transportation, mobile teams, cash transfers, personal resilience – that go beyond the immediate crises but mitigate future challenges. Innovative initiatives that couple practical assistance with key messaging such as the accreditation of vocational training courses seen in Iraq and Syria, the “on-the-wheel” mobile clinics and tuk-tuk ambulances in Sudan and the female-driver project in Syria should be subject to mini-evaluations that explore their scaling-up and/or replicability elsewhere.
9. In particular, the ongoing and worsening effects of **climate change** are starting to affect UNFPA programme countries. The IPCC reports that changing weather patterns are increasing the frequency and intensity of droughts, floods, dust storms, and heatwaves in the MENA region, with women and girls particularly vulnerable due to socio-cultural and legal norms and their role in societies. UNFPA should seek to anticipate and mitigate both the short-term acute effects of extreme climatic events and the overall long-term chronic crisis that they are a symptom of.
10. Leverage the findings and recommendations of the Johns Hopkins University study on the use of **CVA** in Jordan (which found significant benefits by mitigating risks of GBV and improving psychological wellbeing) by developing a strategy (programmatic and resource mobilisation) for including cash assistance as a standard tool within GBV Case Management programs with a view to scaling-up and expanding CVA programming across all countries. Further, interesting and impactful initiatives such as the provision of CVA to pregnant and lactating women in Syria by UNFPA and WFP should be assessed/evaluated for potentially scalability/replicability elsewhere.
11. Following on from the yet-to-be actioned 2021 recommendation, conduct research to understand the barriers to PNC in order to develop a regional campaign, particularly linking PNC as an entry point to family planning, as well as investigating the creation of incentives.





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THE OUTCOMES OF A RANGE OF DIFFERENT CRISES AROUND THE WORLD HAVE THROWN INTO SHARP RELIEF THE VALUE OF THE WORK THAT UNFPA HAS SUPPORTED ACROSS ITS MANDATE AREAS IN THE PAST YEAR.

2022 IMPACT ASSESSMENT OF UNFPA's REGIONAL
HUMANITARIAN RESPONSE
IRAQ, JORDAN, LEBANON, SUDAN, SYRIA,
TÜRKIYE, TÜRKIYE CROSS-BORDER and YEMEN
HUMANITARIAN RESPONSE PROGRAMMES

AGAINST ALL ODDS

VOLUME I
ASSESSMENT REPORT

