EVALUATION REPORT

Evaluation of the UNFPA capacity in humanitarian action (2012-2019)

UNFPA Evaluation Office

2019

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Foreword

The number of people affected worldwide by humanitarian crises continues to rise, as crises are becoming more protracted and increasingly complex. According to recent estimates, more than 168 million people are in need of humanitarian assistance. Against this background, UNFPA plays a critical role in ensuring that sexual and reproductive health and rights and prevention and mitigation of gender-based violence are integrated into humanitarian preparedness, response and recovery phases.

Since the adoption of its Second-generation Humanitarian Strategy in 2012, the role of UNFPA as a humanitarian actor has evolved considerably, with a global humanitarian spend reaching US$ 172,625,466 in 2018, accounting for 31 per cent of total spend that year. In 2019, UNFPA humanitarian action reached over 19 million people in 64 countries, including 7.3 million women who were provided with sexual and reproductive health services, and 1.2 million women and girls who were reached with gender-based violence services. The increasing profile of UNFPA in the global humanitarian system has led the organization to turn its Humanitarian and Fragile Contexts Branch into a full-fledged Humanitarian Office in 2019.

In this context, I am pleased to present the report of the first evaluation of the UNFPA capacity in humanitarian action, which takes stock of the humanitarian effort of UNFPA over almost a decade.

Over the period covered by the evaluation, UNFPA has made great progress in aligning humanitarian programming with its strategic directions. The evaluation found that UNFPA was able to scale up its activities in response to increasing humanitarian needs, with clear output-level results of maternal and newborn health services and some evidence of gender-based violence service-delivery effectiveness.

On the other hand, the evaluation also highlights areas that require improvement. In particular, UNFPA needs to develop a comprehensive strategic framework for its humanitarian action. The evaluation also calls for a review of the corporate approach on preparedness for supplies, including, where necessary, regional stockpiling and national pre-positioning, based on the recognition that, in humanitarian assistance, speed is as critical as cost and quality.

I hope that the body of evaluative evidence as well as the recommendations contained in this report will contribute to shaping a more effective and impactful humanitarian action at UNFPA, in line with the Decade of Action to achieve the 2030 Agenda.

Marco Segone
Director, UNFPA Evaluation Office

(c) UNFPA DRC

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This evaluation would not have been possible without the contribution and commitment of a wide range of stakeholders, within and outside UNFPA.

The Evaluation Office would like to express its gratitude to Representatives and staff in the country offices selected for this evaluation (for field visits and extended desk reviews) for their essential contribution to the evaluation: Bangladesh, Chad, Colombia, the Democratic Republic of the Congo, Haiti, Indonesia, Nigeria, Philippines, the Republic of Sudan, Somalia, the Republic of South Sudan, Turkey, Uganda, Ukraine and Yemen.

Thanks also to programme staff from all business units involved in humanitarian action in headquarters and in regional offices.

Finally, the Evaluation Office would like to thank all the members of the evaluation reference group for their commitment throughout the evaluation process.

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Acronyms

AAP	Accountability to affected populations
AoR	Area of responsibility
APRO	Asia-Pacific Regional Office
ASRO	Arab States Regional Office
BEmOC	Basic emergency obstetric care
CEmOC	Comprehensive emergency obstetric care
CERF	Central Emergency Response Fund
CMR	Clinical management of rape
CPAP	Country programme action plan
CPD	Country programme document
CSO	Civil society organization
DFID	Department for International Development
DHR	Division of Human Resources
DMS	Division of Management Services
DRC	the Democratic Republic of the Congo
DRR	Disaster risk reduction
EECARO	Eastern Europe and Central Asia Regional Office
ERG	Evaluation reference group
ESARO	East and Southern Africa Regional Office
FGM	Female genital mutilation
FTP	Fast-track procedure
GBV	Gender-based violence
GBViE	Gender-based violence in emergencies
GBVIMS	GBV information management system
GCCP	Global Contraceptive Commodity Programme
HCT	Humanitarian Country Team
HFCB	Humanitarian and Fragile Context Branch
HIV	Human immunodeficiency virus
HNO	Humanitarian Needs Overview
HRP	Humanitarian Response Plan
IAFM	Interagency field manual for reproductive health in crises
IARH	Inter-Agency Emergency Reproductive Health
IASC	Inter-Agency Standing Committee
IAWG	Inter-Agency Working Group on reproductive health in crises
ICPD	International Conference on Population and Development
INFORM	Index for Risk Management
LACRO	Latin America and Caribbean Regional Office
LGBT+	Lesbian, gay, bisexual, trans, queer and intersex
MISP	Minimum Initial Service Package for reproductive health in crisis situations
MNH	Maternal and newborn health
MPA	Minimum preparedness action
NTB	Nusa Tenggara Barat (province)
NGO	Non-governmental organization
NWoW	New way of working
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PSB	Procurement Services Branch
PSD	Policy and Strategy Division
PSEA	Protection from sexual exploitation and abuse
PSS	Psychosocial support
REGA	Regional emergency GBV advisor
RH	Reproductive health
SDGs	Sustainable Development Goals
SEA	Sexual exploitation and abuse
SRHR	Sexual and reproductive health and rights
SRHRiE	Sexual and reproductive health and rights in emergencies
STAIT	Senior Transformative Agenda Implementation Team
STI	Sexually transmitted infections
ToC	Theory of Change
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
UNSCR	United Nations Security Council Resolution
WCARO	West and Central Africa Regional Office
WFP	World Food Programme
WFS	Women-friendly space
WGSS	Women and girls' safe space
WHO	World Health Organization
WHS	World Humanitarian Summit
WLCC	Women-led community centre

Executive summary

ABOUT THE EVALUATION

Scope

Within a global context of rising numbers of people affected by increasingly frequent and severe humanitarian crises, UNFPA has sought to meet its mandate under successive strategic planning cycles and under the extant 2012 UNFPA Second-Generation Humanitarian Strategy. Against the background of these humanitarian needs and commitments, the United Nations Population Fund (UNFPA) commissioned an independent, external and objective global evaluation of its humanitarian capacity. This report, covering the period from 2012-2019 and including global-level data as well as specific findings from 15 country contexts, presents the findings, conclusions and recommendations of this evaluation.

Evaluation objectives

The objectives of the evaluation were organized in accordance with best practice evaluation criteria, namely to assess the relevance of humanitarian programming at UNFPA; the extent to which internal systems, processes, policies and procedures allowed for efficient and timely humanitarian action; the effectiveness and coverage of humanitarian action; how connected humanitarian activities are with the longer-term vision and strategic plans of UNFPA; and the extent to which humanitarian principles, minimum standards, human rights and gender equality are integrated into humanitarian action. Finally, the evaluation sought to draw lessons from past and present UNFPA humanitarian work and propose recommendations for future humanitarian programming priorities at UNFPA.

Methods

The evaluation utilized a reconstructed theory of change for UNFPA humanitarian programming to derive the key areas of research for the evaluators. Both primary and secondary qualitative and quantitative data and evidence were collected via a range of methodologies. A total of 437 key informants were interviewed across 15 countries and UNFPA regional and headquarters offices (including mission trips to four humanitarian programme countries and extended desk reviews of another 11). A total of 150 current or past beneficiaries of UNFPA interventions were interviewed in the four field visit countries. In addition to the countries selected for primary data collection, the evaluation team prepared in-depth analyses of two thematic areas: supply-chain management for humanitarian commodities and human resources for humanitarian action, for which specific reports were prepared.

EVALUATION FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

There has been a significant trend of improvement in humanitarian action by UNFPA and progressive, albeit inconsistent, alignment of humanitarian programming with strategic directions.

Evaluation Questions:
1, 2, 4, 6

Findings:
1, 3, 8, 21, 23

Trend of improving response capacity: The evaluation has gathered strong evidence to indicate UNFPA humanitarian response as a whole has significantly and positively evolved from 2012 to 2019. Humanitarian programming is well aligned with specific humanitarian sexual and reproductive health and rights (SRHR) and gender-based violence (GBV) needs in different humanitarian contexts.

There are clear output-level results of maternal and newborn health services and some evidence of GBV service-delivery effectiveness. Youth programming is increasing, but still nascent, with examples across most countries of increased consideration for youth-friendly/adolescent-friendly services. There is also evidence of an evolution of humanitarian response across different phases of a crisis, adapting to changing needs of affected populations.

Evaluation Question: 6 **Findings:** 21, 23	**Still an overarching development focus:** UNFPA has progressively mainstreamed humanitarian assistance in all its strategies and programmes, notably in line with the UNFPA Strategic Plan 2014-2017. However, this evolution has not been uniform and the overarching institutional approach remains predominantly development-orientated. This presents challenges to effective humanitarian programming, particularly when seeking to balance financial risk and response timeliness, managing human resources to best effect (via surge and other mechanisms) and management of humanitarian commodity supply chains.
Evaluation Questions: 1, 4 **Findings:** 3, 5, 13	The second-generation humanitarian strategy was relevant to UNFPA in 2012 and it has set the ground for the mainstreaming of humanitarian action in subsequent strategic documents. However, due to the changing global humanitarian context and the evolving UNFPA role within humanitarian action, the strategy requires updating.
Priority: High **Target:** Humanitarian Office/Senior management	**RECOMMENDATION 1** **UNFPA should develop a strategic framework for humanitarian action.** This should account for: • Changes in the external environment and within global humanitarian architecture structures since the previous UNFPA humanitarian strategy in 2012 • A stronger UNFPA role within this architecture • Working across and bringing together the constituent parts of the triple nexus • The need to integrate humanitarian response within the overarching UNFPA Strategic Plan • The need for effective resource mobilization that facilitates timely responses to crises.

UNFPA has only limited capacity to demonstrate results or outcomes.

Evaluation Question: 4 **Findings:** 11, 12, 14, 15	**Use of monitoring systems:** While UNFPA has invested in useful monitoring systems, they are not systematically or consistently utilized, leading to a lack of coherent and comprehensive data on the results of UNFPA activities on peoples' health and welfare. Thus, the effectiveness of UNFPA cannot be fully or reliably measured in many country contexts or aggregated at regional or global levels. It also presents challenges to setting appropriate targets for results and to determining whether UNFPA humanitarian action meets internal and external quality standards.
Priority: High **Target:** Policy and Strategy Division and Humanitarian Office	**RECOMMENDATION 2** **UNFPA should review existing datasets and monitoring systems to identify current gaps and bottlenecks and use this to develop a comprehensive data management system.** This should be integrated into the new Enterprise Resources Platform currently being developed and should focus on both data management at indicator level and data collection systems to distinguish types of data (e.g., output/outcome) and purposes of data (e.g., programming, advocacy, communications) and to ensure comparability and consolidation at all levels.

Needs assessment and targeting are present but ad hoc, with missed opportunities and duplication.

Evaluation Question: 1, 3, 5, 8 **Findings:** 1, 9, 10, 18, 29, 30	There are many examples of needs assessment, geographical and demographic targeting processes being successfully applied across humanitarian and fragile settings. There are also many examples of UNFPA working with women and youth civil society. However, there is no systematic approach to these processes. UNFPA staff frequently struggle to access adequate corporate guidance, miss opportunities for synergy and duplicate efforts in developing/implementing basic approaches, tools and processes. Notable examples include needs assessments for accessing emergency funds; adapting programming from immediate to longer-term responses; and mechanisms for accountability to affected populations (AAP) and protection from sexual exploitation and abuse (PSEA).

Priority: Low **Target:** Policy and Strategy Division and Humanitarian Office	**RECOMMENDATION 3** **The UNFPA knowledge management approach should include a work plan to ensure ongoing embedding of corporate guidance on humanitarian processes at field level.** This should link to the new Enterprise Resources Platform and the policies and procedures repository in use but bottlenecks, gaps or access issues with respect to humanitarian knowledge/practice should be systematically identified and addressed to maximize the utility of these resources to country offices.

In a difficult resource environment, UNFPA has performed well but should align its level of risk acceptance with the requirements of humanitarian action.

Evaluation Question: 6 **Findings:** 20, 23	**Resource mobilization:** While it has become more difficult for UNFPA to mobilize core resources to deliver its mandate at the global level, UNFPA has been increasingly successful in mobilizing other humanitarian resources at the country level, such as pooled funds. Within this funding context, the main issue for UNFPA consists in setting priorities for the allocation of UNFPA humanitarian funds across mandate areas.
Evaluation Question: 6 **Finding:** 23	**Commodity supply chains:** UNFPA has good practices in terms of the delivery of inter-agency reproductive health (RH) kits at the beginning of an emergency. However, UNFPA is perceived as being slow and not always matching other agencies in this regard, although there are regional variations. Currently, the supply chain model operated by UNFPA is not optimal or specific for humanitarian response, but before systems can change, UNFPA must recognize it is not possible to be an effective humanitarian supplies agency without taking a higher level of risk with the aim of ensuring timely delivery.
Priority: High **Target:** Humanitarian Office, Procurement Services Branch, Division of Management Services, Senior management	**RECOMMENDATION 4** **UNFPA should review the corporate approach on preparedness for supplies, including, where necessary, regional stockpiling and national pre-positioning.** This should include an organization-wide preparedness policy, involving regional stockpiling and national pre-positioning that considers differentiating between contexts and types of commodities and integrating learning from ongoing initiatives. The UNFPA approach to regional stockpiling and national pre-positioning should be based on the fundamental concept of speed being as critical a factor in humanitarian response as cost and quality. UNFPA should also include a review of human resources for humanitarian logistics and continual monitoring of commodity delivery times and availability in line with supply chain management best practices of consistency and robustness.
Evaluation Question: 5, 6 **Findings:** 17, 21	**Humanitarian human resources:** The number of highly knowledgeable humanitarian experts available to UNFPA is not commensurate with its humanitarian accountabilities. Humanitarian capacity (in terms of quantity of specialized staff and the quality of expertise among staff at all levels) is insufficient to deliver fully on mandate and commitments. This limits the capacity to operate within modern humanitarian architecture at country levels and impedes advancement of UNFPA as a major humanitarian actor. This is most clearly exemplified by frequent lack of understanding of the humanitarian architecture, the operational flexibility provided by fast-track protocols, the cluster system, what it means to be a cluster lead agency, pooled funding mechanisms, differences between GBV and PSEA and humanitarian principles.

Priority: High **Target:** Humanitarian Office, Division of Human Resources	**RECOMMENDATION 5** **UNFPA should develop a comprehensive plan for increasing humanitarian expertise.** This should include a five-year humanitarian human resources strategy for increasing general humanitarian expertise from a clearly understood baseline and with a realistic goal. The strategy should cover new and existing personnel (including senior management) and systematically utilize deployed humanitarian personnel (roving team and surge) for skills transfer to both incoming replacements and national country office staff. The strategy should also provide appropriate resources to the UNFPA Division of Human Resources to ensure speed, consistency and quality in the identification, recruitment, deployment and follow-up of humanitarian personnel.
Evaluation Question: 1, 5 **Findings:** 4, 19	**Vulnerable groups:** Inclusion analysis is integrated within UNFPA humanitarian programming, but it is not fully aligned with the principle of leaving no one behind. Specific groups of focus are: • **Women and girls:** More analysis is needed to identify and effectively reach specific and disaggregated groups of vulnerable women and girls • **Adolescents and youth:** UNFPA has successfully increased focus on adolescents and youth within its programmes • **Persons with disability:** The evaluation noted widespread recognition of a need to ensure inclusion of people with disabilities, but limited evidence that programming is achieving this • **LGBT+ populations (lesbian, gay, bisexual, transgender and related communities):** Little or no inclusion of humanitarian action to reach these populations which are within the mandate and global commitment of UNFPA.
Priority: Low **Target:** Humanitarian Office, Policy and Strategy Division	**RECOMMENDATION 6** **UNFPA should develop an inclusion strategy that is based on leaving no one behind and incorporates reaching the furthest behind first.** This should be developed from current (August 2019) global guidance on inclusion, which notes that UNFPA will address *"inequity in access to, the poor quality of and the lack of social accountability for sexual and reproductive health services in all contexts, including humanitarian and fragile contexts and in public health emergencies."* The strategy should provide pragmatic and practical guidance on ensuring inclusion within humanitarian settings. It should specifically cover geographically hard-to-reach groups, women and girls, adolescents and youth, persons with disabilities and LGBT+ populations..
Evaluation Question: 3 **Findings:** 9, 10	**Accountability to affected populations (AAP):** UNFPA has improved AAP. However, it still does not adequately address these important areas at all levels. For AAP, knowledge – both as a concept and more practically (i.e., how to establish feedback mechanisms) – is inconsistent across countries, with limited guidance from headquarters on global best practice for this, although there are ongoing efforts to improve accountability. **Protection from sexual exploitation and abuse (PSEA):** UNFPA has significantly increased the level of guidance on UNFPA responsibilities in PSEA for UNFPA staff, programmes and partners but this has yet to manifest in a tangible manner across country-level implementation, where expertise within UNFPA remains basic.

Priority: Low **Target:** Humanitarian Office, regional offices	**RECOMMENDATION 7** **UNFPA should undertake a mapping of existing AAP initiatives at country level with a view to incorporating good or promising practice guidance.** Based on identified good or promising practices on AAP, UNFPA should develop humanitarian-specific pragmatic guidance on how best to establish sustainable feedback channels accessible by all vulnerable persons (taking into account unique challenges of displaced, conflict, hard-to-reach populations) and systematic mechanisms for incorporating feedback into the programming cycle.
Priority: High **Target:** Humanitarian Office, regional offices, PSEA Coordinator	**RECOMMENDATION 8** **UNFPA should conduct a survey of knowledge and capacity for PSEA at country level to establish the current bottlenecks between global level and country level.** This should be used as a basis to identify where UNFPA remains at highest risk regarding sexual exploitation and abuse and to develop a resourced work plan to systematically reduce this risk at the field level where day-to-day contact with vulnerable women and girls within communities (by both UNFPA and partner staff) represents the highest risk.

UNFPA demonstrates a positive trend of working with national actors and humanitarian coordination, but some sectoral gaps remain, particularly around youth.

Evaluation Question: 2, 4, 8 **Findings:** 6, 7, 16, 29, 30	**Government partners:** UNFPA has a demonstrated and laudable record of close relationships with government partners within development contexts – a clear comparative advantage for humanitarian action. This positions UNFPA very well within the current humanitarian direction of the New Way of Working (NWoW) and working toward collective outcomes across the humanitarian-development-peace nexus, despite the absence of a global strategy to optimally leverage this position. However, close relationships with governments in some contexts (e.g., conflict areas) present a risk vis-à-vis humanitarian principles of neutrality, impartiality and independence.
Evaluation Question: 6, 8 **Findings:** 24, 30	**Civil society partners:** UNFPA is committed to prioritizing the localization agenda as introduced in the Grand Bargain commitments and improvements have been made on this between the adoption of the Grand Bargain following the World Humanitarian Summit in 2016 and 2018. However, UNFPA has yet to develop a global strategy to ensure localization of aid, targeting specifically grassroots women's organizations and youth organizations within humanitarian response.
Evaluation Question: 7 **Findings:** 25, 26, 27, 28	**Humanitarian coordination structures:** UNFPA leadership and coordination via Inter-Agency Standing Committee humanitarian structures (areas of responsibility, sub-clusters and workings groups) have significantly improved in recent years, with the following caveats: • While the evaluation notes evidence of improved coordination of the GBV area of responsibility, many GBV sub-clusters at country level are under-resourced. • UNFPA leadership of RH working groups is effective where present. However, in crises where working groups are not present, sexual and reproductive health and rights are deprioritized, particularly beyond elements of maternal and neonatal health. • Absence of UNFPA coordination leadership for youth at country level precludes meeting of global commitments assumed with the Compact for Young People in Humanitarian Action and United Nations Security Council Resolution 2250 on youth, peace and security. • The role of UNFPA as the United Nations entity for population and the associated expertise in development settings has not been leveraged sufficiently for humanitarian action across all actors.

Priority: Medium **Target:** Humanitarian Office	**RECOMMENDATION 9** **UNFPA should develop a resource plan for ensuring that GBV sub-clusters are resourced equivalently to other clusters with well-capacitated coordinators and technical support.** This should include ensuring that the UNFPA GBV minimum standards are adhered to, including appointment of a sub-cluster coordinator and addressing key coordination challenges such as high turnover of coordination staff, excessive coordination workloads (double/triple-hatting) and lack of information management functions within sub-clusters.
Priority: Medium **Target:** Humanitarian Office	**RECOMMENDATION 10** **UNFPA should develop a plan to systematize establishment and functioning of RH working groups.** This should include support for a mechanism to monitor functioning RH working groups led by UNFPA; assessment of the impact of absence of RH working groups within response systems; and systematically monitoring achievements and added value of RH working groups.
Priority: Medium **Target:** Humanitarian Office	**RECOMMENDATION 11** **UNFPA should address the gap between global-level leadership in the areas of humanitarian response and peace and country-level tangible action** This should include a survey of crises where UNFPA leads a functioning coordination mechanism for young people in action and where gaps remain; determining resources required to translate UNFPA global commitment into country-level action; a review of potential partners (for resources and collaboration) and a position statement for youth and peace outlining commitments to country-level action.
Priority: Medium **Target:** Humanitarian Office	**RECOMMENDATION 12** **UNFPA should review the activities referenced within the 2018 letter of understanding with the United Nations Office for the Coordination of Humanitarian Affairs as a foundation for increasing the UNFPA data footprint within humanitarian action.** This should incorporate a vision statement and three- to five-year plan on humanitarian population, health and gender data at global, field and country levels. It should also include resource requirements (platforms, staffing, a funding strategy) and a work plan, including the activities outlined in the 2018 letter of understanding.

(c) UNFPA, Anne Wittenberg, Women and girls who just arrived at a new internally displaced persons settlement in Nigeria

1 INTRODUCTION

This report is organized into five sections.

Section 1 is an introduction that provides an overview of the global context of humanitarian needs within which UNFPA operates and within which this evaluation has taken place.

Section 2 provides an overview of the methodology used, with more detailed information in Annex I.

Section 3 presents the findings of the evaluation. The findings are organized under eight evaluation questions. For each evaluation question, there is a list of relevant findings presented with the evidence collected through the evaluation process.

Section 4 presents conclusions drawn from the findings.

Section 5 presents recommendations based on the findings and conclusions.

BACKGROUND

The number of people affected worldwide by humanitarian crises continues to rise as both the frequency and severity of natural disasters and protracted, complex emergencies increase. The United Nations has calculated global humanitarian requirements for 2019 of US$21.9 billion to reach 93.6 million people out of a total of 131.7 million people in need[1]. Both the scale and nature of displacement have changed, with the latter becoming more protracted and in multiple waves over time with populations being secondarily or repeatedly displaced. Displacement is also increasingly manifested within urban settings and out-of-camp settings, as opposed to traditional camp settings. Cyclical disasters – particularly those which are climate-change driven – are increasing in frequency and scale and historical drivers of conflicts are re-emerging with new dimensions.

The year 2016 marked the 25th anniversary of United Nations Resolution 46/182[2] , which laid the foundation for the current global humanitarian response system, with structures, tools, responsibilities and principles as necessary today as they were in 1991. The US$21.9 billion in humanitarian assistance funding required for 2019[3] is a tenfold increase over the first inter-agency humanitarian appeal in 1992 of US$2.7 billion. Since Resolution 46/182, the continuing evolution of the global humanitarian ecosystem has been iterative but relatively haphazard, despite varying efforts by key stakeholders to structure the changing architecture as it emerges.

Emerging from these efforts, several changes have occurred in the global humanitarian architecture in the past two decades, the most prominent of which include:

- The Humanitarian Reform Agenda in 2005, which resulted in the establishment of the extant cluster system.
- The Transformative Agenda in 2011, which was based on the three pillars of improved coordination, improved leadership and improved accountability.
- The World Humanitarian Summit (WHS) in 2016, from which stemmed:
    - The Grand Bargain: an agreement among 22 donors and 31 humanitarian agencies on a range of improvements to the humanitarian system, such as the localization of aid, with a commitment of 25 per cent of all funding going directly to local and national responders by 2020; increased predictability of funding and therefore improved efficiency of programming by moving to multi-year funding where possible; decreased reporting burdens by harmonizing reporting requirements; and increased commitments to cash-based programming.

1. OCHA. Global Humanitarian Overview, 2019. 2019.
2. General Assembly Resolution A/RES/46/182: Strengthening of the coordination of humanitarian emergency assistance of the United Nations
3. OCHA. Global Humanitarian Overview, 2019. 2019.

- The New Way of Working (NWoW), which responds to the need to strengthen the humanitarian-development continuum/nexus. The NWoW recognizes that inter-agency appeals now last an average of seven years[4] and therefore increased dovetailing of humanitarian and development goals is logical. The NWoW has, at its heart, a notion of 'collective outcomes' which seeks to provide both immediate humanitarian assistance and protection as well as to reduce exposure to risk and vulnerability over the longer term under the framing of the Sustainable Development Goals (SDGs) and Agenda 2030.

Within this global context, UNFPA has sought to meet its mandate under successive strategic planning cycles and under the 2012 UNFPA Second-Generation Humanitarian Strategy. Within this, humanitarian strategic priorities at UNFPA are based on both its mandate and its identified comparative strength in humanitarian settings, namely:

The provision of emergency SRH services is a key component of essential life-saving activities. Gender issues, particularly sexual violence and other forms of gender-based violence, often become more acute in humanitarian settings…Cross-cutting themes of gender and age will be considered through all areas of intervention. The new strategy is not a radical departure from past efforts by UNFPA in emergency preparedness, response and recovery, but it does represent a substantial shift in business practices.[5]

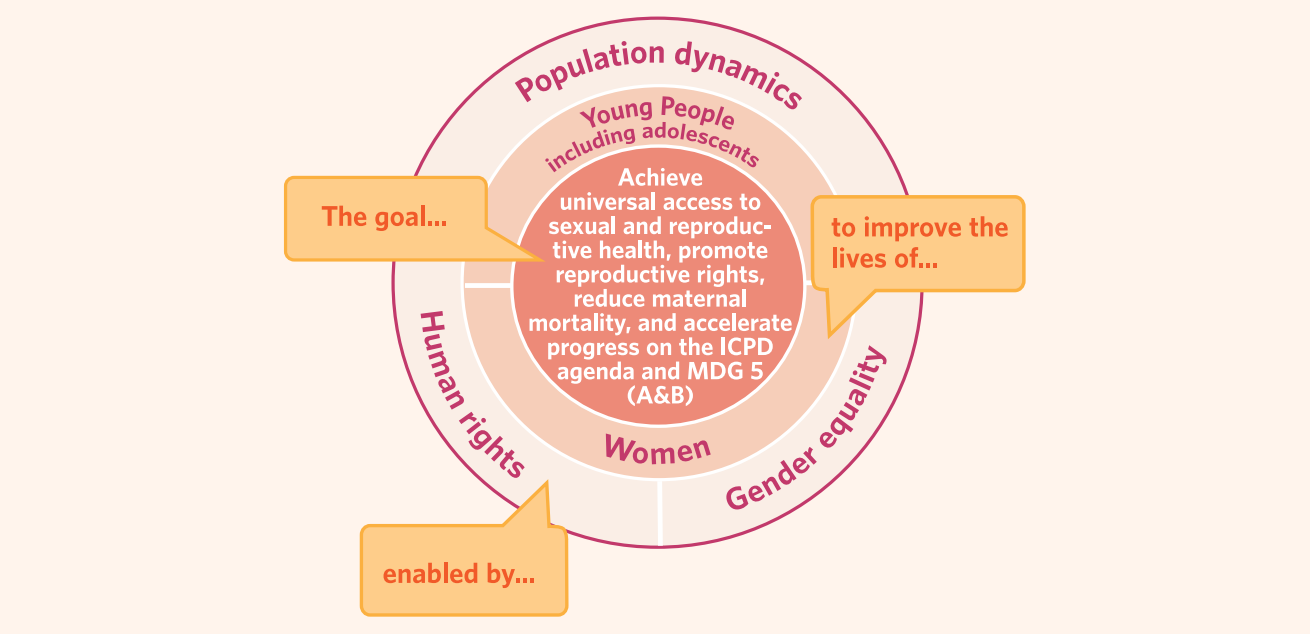
This humanitarian strategy includes addressing maternal and newborn health services (MNH), human immunodeficiency virus (HIV), gender equality and reproductive rights and improved access to SRH services and sexuality education for young people. Gender-based violence (GBV) is addressed under the gender equality and reproductive rights outcome.

The UNFPA Strategic Plan 2014-2017 was centred on the UNFPA 'bull's eye':[6]

Subsequently, the UNFPA Strategic Plan 2018-2021 builds upon the bull's eye, linking it to the goals and indicators of the 2030 Agenda for Sustainable Development[8] and strengthening reference to humanitarian action.[9] This plan outlines key areas for collaboration against the Agenda 2030 principles of leaving no one behind and reaching the furthest behind first and is framed through three universal and people-centred transformative results:

1. Ending preventable maternal death
2. Ending the unmet need for family planning
3. Ending GBV and all harmful practices, including child marriage and female genital mutilation.

FIGURE 1: *The UNFPA bull's eye* [7]



4. OCHA. An end in sight: Multi-year planning to meet and reduce humanitarian needs in protracted crises. 2015.
5. UNFPA. Second Generation Humanitarian Strategy. 2012.
6. This evaluation covers three UNFPA strategic planning periods, 2008-2013, 2014-2017 and 2018-2021. In line with a forward-looking and formative evaluation approach, the evaluation framework has been aligned to the UNFPA Strategic Plans 2014-2017 and 2018-2021.
7. UNFPA Strategic Plan 2014-2017. 2013
8. General Assembly Resolution A/RES/70/1: Transforming our world: the 2030 Agenda for Sustainable Development
9. UNFPA Strategic Plan 2018-2021. 2017

In line with these strategic directions, humanitarian action for UNFPA currently focuses on GBV, sexual and reproductive health and rights (SRHR) and, more recently, youth and data.

GBV in emergencies (GBViE): In line with global good practice, UNFPA programmes to address GBViE prioritize a focus on the rights and needs of girls and women, given their particular vulnerability over the lifecycle to multiple forms of violence that are rooted in systemic gender-based inequality existing within and across all societies.[10] In 2015 UNFPA produced a reference guide, Minimum Standards for the Prevention and Response to Gender-based Violence in Emergencies.[11] This guide outlines 18 standards across three themes of:

- Foundational standards
- Mitigation, prevention and response standards
- Coordination and operational standards.

UNFPA also has adopted additional GBV coordination responsibilities under the Inter-Agency Steering Committee (IASC) architecture. UNFPA has been co-leader (with the United Nations Children's Fund - UNICEF) of the GBV Area of Responsibility (AoR) since 2006, but in 2016 UNFPA took on sole leadership for this, which is one of four distinct AoRs within the Global Protection Cluster (led by the United Nations High Commission for Refugees, UNHCR).[12]

The GBV AoR Coordination Team (www.gbvaor.net) currently has a broad membership with a complement of six full-time staff[13] at the global level and a series of member working groups focused on specific learning, policy, advocacy, localization and the development of standards.

Its 2015-2020 capacity building strategy outlines how the GBV AoR "works to promote a comprehensive and coordinated approach to GBV at the field level" through four key areas of work: (a) supporting field operations; (b) building knowledge and capacity; (c) setting norms and standards; and (d) advocating for increased action, research and accountability at global and local levels.

The GBV AoR provides direct support to GBV sub-clusters at the country level and also manages a team of regional emergency GBV advisors (REGAs)—rapidly deployable senior technical experts used to strengthen country-level inter-agency humanitarian response to GBV. The GBV AoR has additionally supported the development and uptake of a variety of tools and resources, including:

- The 2019 Handbook for Coordinating Gender-based Violence in Humanitarian Settings (revised from 2010)
- GBV Standard Operating Procedures
- GBV Information Management Toolkit
- The 2015 IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action.[14]

The work of the GBV AoR has been bolstered by the Call to Action on Protection from Gender-Based Violence in Emergencies (Call to Action) which is a multi-stakeholder initiative launched in 2013.[15] The GBV area of responsibility also has a help desk and a general community of practice, both focused primarily on supporting the GBV sub-clusters and programme specialists and also co-leads a child and adolescent survivor community of practice with the child protection AoR.

In addition to the coordination work undertaken by the GBV AoR, UNFPA leads on coordinating the Real Time Accountability Partnership (RTAP), which seeks to expand accountability for addressing GBV in humanitarian response. UNFPA leads on the GBV Information Management System (GBVIMS) and the GBV area of responsibility supports synergies and information sharing.

Sexual and reproductive health and rights in emergencies (SRHRiE): After the 1994 International Conference on Population and Development (ICPD), the Inter-Agency Working Group (IAWG) on reproductive health in crises was formed. This group focused on policy and programme practice, producing the Inter-Agency Field Manual (IAFM) in 1995, which included a set of minimum RH services required in humanitarian response – the Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations. The IAFM is the leading reference document for SRHRiE. The MISP is embedded within the Sphere standards[16] (from the 2004 edition onwards, within the Health Action chapter), which are universally acknowledged as the primary minimum standards for humanitarian programming.

10. https://www.unfpa.org/gender-based-violence
11. UNFPA. Minimum Standards for the Prevention and Response to Gender-based Violence in Emergencies. 2015
12. Note that under the cluster system, cluster lead agencies lead on coordination under the inter-agency standing committee architecture for internally displaced populations. UNHCR lead on all sectors for refugee coordination where often coordination is shared for GBV between UNHCR and UNFPA.
13. GBV AoR key informants.
14. All tools and standards can be found on the new user-friendly GBV AoR website www.gbvaor.net
15. https://www.calltoactiongbv.com
16. Information on Sphere standards can be found at https://www.spherestandards.org

BOX 1: THE MINIMUM INITIAL SERVICES PACKAGE, AS PRESENTED IN THE 2018 INTER-AGENCY FIELD MANUAL ON REPRODUCTIVE HEALTH IN HUMANITARIAN SETTINGS

1. Ensure the health sector/cluster identifies an organization to lead implementation of the MISP
2. Prevent sexual violence and respond to the needs of survivors
3. Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs
4. Prevent excess maternal and newborn morbidity and mortality
5. Prevent unintended pregnancies
6. Plan for comprehensive SRH services to be integrated into primary health care as soon as possible. Work with the health sector/cluster partners to address the six health system building blocks.

Source: http://iawg.net/iafm/

In 1998, UNFPA became the global custodian for the Inter-Agency Emergency Reproductive Health (IARH) kits and currently supplies life-saving reproductive health commodities to numerous partners across different humanitarian contexts.[17,18] UNFPA launched its supplies programme (not specifically for humanitarian programming) in 2007 and this is now recognized worldwide as the main channel for assisting countries to achieve reproductive health commodity security within development settings.[19] Since 2007, this programme has increased its outreach from 12 to 46 countries, out of which 35 experienced some form of humanitarian crisis during 2017.[20] Given the increasing evidence that reproductive health indicators in fragile contexts are particularly poor, with over 60 per cent of global maternal mortality occurring within countries affected by fragile and humanitarian contexts,[21] this commodity support in crises is particularly critical.[22]

Working with and for young people in humanitarian action: Together with the International Federation of the Red Cross, UNFPA leads the Compact for Young People in Humanitarian Settings[23], which was an outcome of the 2016 WHS.

The compact has five key actions for accountability to young people in humanitarian action, which cover ensuring humanitarian programming contributes to the protection, health and development of young people, supporting systematic engagement with youth in humanitarian action, strengthening young people's capacities to be effective humanitarian actors, increasing resources to address the needs of young people in humanitarian contexts and increasing utilization of age- and sex-disaggregated data.[24]

UNFPA also has an emerging global leadership role around United Nations Security Council Resolution (UNSCR) 2250[25] on Youth, Peace and Security, adopted in 2015. Resolution 2250 recognizes that young men and women play an important role in the promotion and maintenance of international peace and security. The resolution requested the Secretary-General to conduct a progress study on young people's positive contribution to peace processes and conflict resolution. The accountability for secretariat functions for this was delegated to UNFPA and the United Nations peace-building support office, which is the foundation for the emerging youth and peace leadership role of UNFPA.[26]

With leadership and responsibilities associated with both initiatives, UNFPA is evolving as a clear youth coordination voice at the global level.

Humanitarian Data: Humanitarian data is a complex issue which continues to present a bottleneck to effective humanitarian action. The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) produces an annual Humanitarian Data and Trends report,[27] which, however, highlights funding trends and high-level analysis of geographic coverage rather than disaggregated population data. In 2010, UNFPA produced the Guidelines on Data Issues in Humanitarian Crises.[28] The document outlines that:

UNFPA, as lead agency in the domain of data for development and with lengthy experience and expertise in data issues, has conceived the Guidelines for Data Issues in Humanitarian Crisis Situations to address key data issues related to the preparedness, acute, chronic and post-crisis phases of humanitarian emergencies.[29]

17. https://www.unfpa.org/resources/emergency-reproductive-health-kits
18. Note that there is a specific thematic paper on supply-chain management for humanitarian commodities (including both IARH kits and dignity kits) at UNFPA, which provides more detailed evidence on the use of IARH kits.
19. UNFPA. UNFPA Supplies Annual Report. 2017
20. Ibid.
21. UNFPA. Maternal Mortality in Humanitarian Crises and in Fragile Settings. 2015.
22. See the thematic paper on supply-chain management for humanitarian commodities for more detailed information.
23. https://www.agendaforhumanity.org/initiatives/3829
24. https://www.agendaforhumanity.org/initiatives/3829
25. https://www.un.org/press/en/2015/sc12149.doc.htm
26. https://www.unfpa.org/youth-peace-security
27. Such as 2017: http://interactive.unocha..org/publication/datatrends2017/resources/WHDT2017_Final_Singles.pdf
28. https://www.unfpa.org/sites/default/files/pub-pdf/guidlines_dataissues.pdf
29. Ibid.

It further states that the guidelines provide action points for every phase of a humanitarian response to *"enhance the effective participation of UNFPA country offices during each phase of a humanitarian crisis by providing them with some directives on what to do and with whom."*[30]

In 2017, UNFPA commenced a partnership with OCHA to build upon census data, registry data and other surveys to contribute toward humanitarian needs overviews, together with mapping vulnerable populations using geospatial data and expanding the Index for Risk Management (INFORM)[31] datasets to include maternal mortality indicators. The 2018 UNFPA Humanitarian Action Overview highlights that improving population data systems in humanitarian and fragile contexts aligns with the Grand Bargain commitments of UNFPA and with the UNFPA Strategic Plan 2018-2021 and further recognizes that "[i]ncreased delivery of UNFPA population data expertise within humanitarian situations has high multiplier effects for improving humanitarian response across all sectors. It sharpens the underlying rationale and the evidence base behind priority locations, scale and people in need."[32]

EVALUATION PURPOSE, OBJECTIVES AND SCOPE

Against the background of the humanitarian commitments, strategies and actions presented above, UNFPA commissioned this independent, external and objective global evaluation assessing its organizational capacity in humanitarian action, in terms of both preparedness and response.

The specific objectives of this evaluation are:

a. To assess the relevance of humanitarian programming at UNFPA

b. To assess the extent to which internal systems, processes, policies and procedures related to humanitarian programming at UNFPA allow for efficient and timely humanitarian action, at all levels of the organization (global, regional and national)

c. To assess the effectiveness as well as the coverage of humanitarian action undertaken by UNFPA, in terms of preparedness, response to and recovery from humanitarian crises

d. To assess the extent to which the UNFPA humanitarian interventions are connected with the organization's longer-term vision and strategic plan in order to ensure a continuum between humanitarian, development and sustaining peace efforts (addressing the humanitarian-development-peace nexus)

e. To analyse the extent to which humanitarian principles (humanity, neutrality, impartiality, independence), humanitarian minimum standards, human rights and gender equality are integrated into humanitarian action at UNFPA

f. To draw lessons from past and present UNFPA humanitarian work and propose recommendations for future humanitarian programming priorities at UNFPA.The scope of the evaluation has three dimensions:

- **Geographically:** global, with a focus on all countries considered as priority countries by UNFPA since 2014. The evaluation is not intended to evaluate separately individual country programme responses

- **Thematically:** the evaluation considers all types of humanitarian settings/contexts, including L1, L2 and L3 emergencies; rapid-onset emergencies; protracted crises as well as specific contexts such as small island developing states (SIDS), both in terms of preparedness and response. This primarily incorporates directly-supported reproductive health and GBV interventions (though also potentially other work with affected populations), as well as the coordination role of UNFPA

- **Temporally:** the 2012-2018 period with respect to the relevance, efficiency and timeliness of UNFPA programming (objectives a. and b.); and the 2014-2018 period with respect to the effectiveness, coverage and connectedness of UNFPA work (objectives c. and d.).[33]

The primary intended users of the evaluation are:

- UNFPA country offices
- UNFPA regional offices
- UNFPA Humanitarian Office[34]
- UNFPA senior management, including the Executive Board.

30. Ibid.
31. http://www.inform-index.org/
32. UNFPA, 2018, Humanitarian Action Overview, https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_HumanitAction_2018_Jan_31_ONLINE.pdf
33. While the evaluation terms of reference specify the 2012-2018 period to be covered by the evaluation, the research/data collection and review period took place into 2019, with additional information coming to light from that year. The evaluation team has sought to incorporate such information where relevant and practical.
34. This evaluation covers the period 2012-2018, during which time UNFPA humanitarian response was conducted under the Humanitarian and Fragile Contexts Branch (HFCB). In 2019 this branch has been converted to the Humanitarian Office (HO).

(c) UNFPA, Anne Wittenberg, Women getting water in an internally displaced persons camp in Nigeria

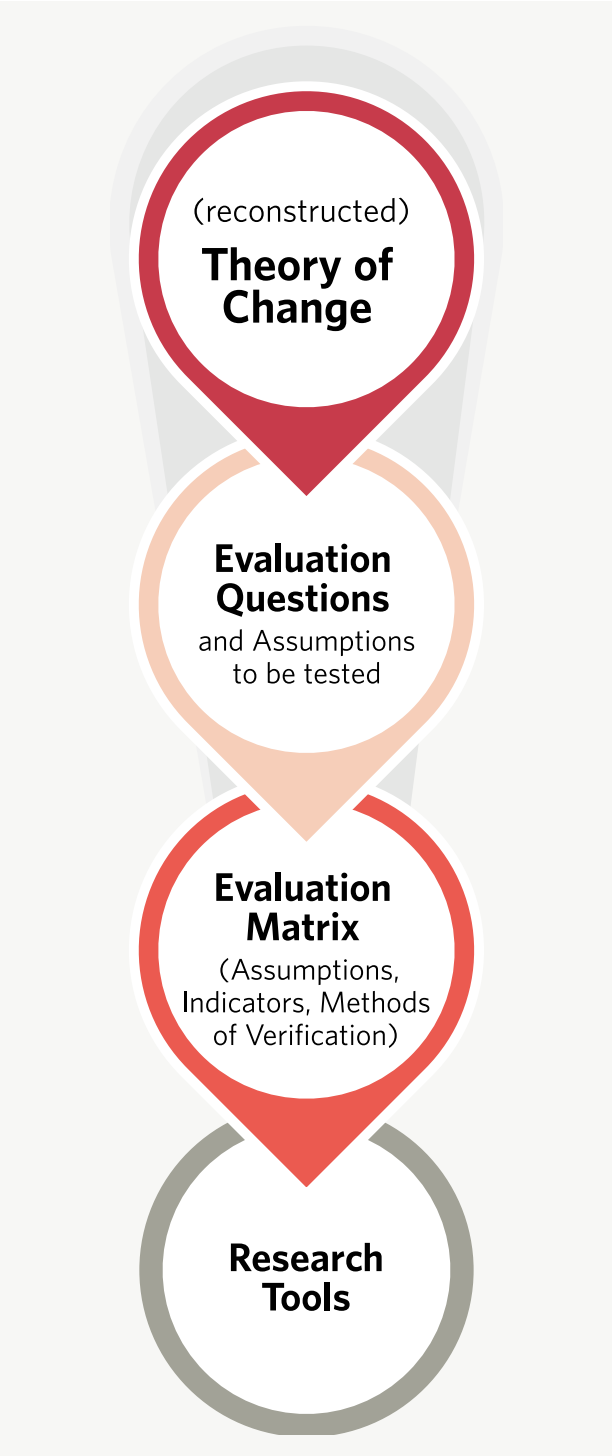
2 METHODOLOGY AND APPROACH

The evaluation was conducted in accordance with the United Nations Evaluation Group Norms and Standards for Evaluations and Ethical Guidelines for Evaluation. The evaluation also conforms to the handbook *How to Design and Conduct a Country Programme Evaluation at UNFPA* and the World Health Organization (WHO) *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies.* It also adheres to the principles of independence and impartiality, credibility and utility.

The methodological design (articulated within the inception report and finalized after the pilot mission to Haiti in January 2019) was developed based on an analytical framework used to outline what the evaluation should look at and how that would be done.

As part of the initial scoping and inception process of the evaluation, the research team, with iterative consultation from members of the evaluation reference group (ERG), constructed a theory of change (ToC) for UNFPA humanitarian programming globally. While UNFPA has not applied an overall ToC to its previous or current humanitarian programming, the evaluation team reconstructed intervention logic for UNFPA humanitarian response work in general, linked to key strategic and programmatic outputs and outcomes of UNFPA and humanitarian actors globally. From this, the evaluation team derived the **evaluation questions**, which set out the key areas of research that were tested by the evaluators. Each of these questions has associated **assumptions**, which were tested by the evaluators via indicators for which primary and secondary data were collected and analysed via the **research tools**. A diagrammatic representation of the analytical process is presented below:

FIGURE 2: *Evaluation design and analytical process*



RECONSTRUCTED THEORY OF CHANGE

The reconstructed theory of change is presented in Annex III. It outlines the causal chain between the problem statement and the UNFPA impact goal, showing specific inputs, outputs and outcomes between the two. The final evalution questions and associated assumptions to be assessed are presented in the evaluation matrix, which includes a summary of all coded and cleaned evidence and data gathered over the course of the evaluation (see Annex V).

The final countries selected by the ERG to participate in the evaluation[35] were:

TABLE 1: *Country visits and extended desk reviews*

Country Visits	Extended Desk Reviews
The Democratic Republic of the Congo (DRC), Haiti (pilot mission), Indonesia, Ukraine	Bangladesh, Chad, Colombia, Nigeria, Philippines, Republic of Sudan[36], Somalia, The Republic of South Sudan, Turkey, Uganda, Yemen

Countries were selected for the evaluation research based on the following criteria:

- UNFPA region of intervention (Asia-Pacific, Arab States, East and Southern Africa, Eastern Europe and Central Asia, Latin America and Caribbean and West and Central Africa)
- Significance of commitment of UNFPA support (financial, human, technical)
- Level of crisis (L1/L2/L3)
- Nature of crisis (conflict/natural disaster)
- Duration (sudden onset versus protracted crisis)
- Affected populations (internally displaced persons/refugees/non-displaced & host communities)
- UNFPA coordination/leadership role (GBV sub-cluster / reproductive health working group / and youth working groups and/or task teams)
- Logistical feasibility of field mission (travel time, security – for field visit countries only).

The intention of the evaluation team was to leverage the expertise of the ERG to ensure a representative spread of participating countries from all UNFPA geographical regions (notably with representation of all regional offices) and a mixture of variable levels of response by UNFPA, so as not to over-represent specific modalities or scale of humanitarian response.

In practice, one of the five countries selected for a direct field visit, the Republic of Sudan, experienced significant civil and political unrest from March/April 2019 onward, the time when the field research team was due to travel for data collection. These ongoing security challenges resulted in the field visit to Sudan being ultimately cancelled. There was no clear alternative for field research that would not have impacted on the evaluation timeline or on the representativeness of the countries. Therefore, the ERG approved reduction of the number of field visit countries to four and the conversion of Sudan to an extended desk review. In addition to the 15 countries, the ERG voted on themes for two thematic papers during the inception phase and the choices confirmed were:

- Supply-chain management for humanitarian commodities
- Human resources for humanitarian action

Both primary and secondary qualitative and quantitative data and evidence were collected via a range of methodologies, as follows:

TABLE 2: *Primary and secondary qualitative and quantitative data sources*

	Field Visit Countries (4)	Desk Review Countries (11)	Thematic Areas (2)
Secondary documentation (reports, strategies, plans, papers, policies, etc.)	✓	✓	✓
Secondary quantitative data (financial, monitoring, census/ demographic health surveys/multi-indicator cluster surveys, etc.)	✓	✓	✓
Key informant interviews	✓	✓	✓
Community focus group discussions	✓		
Site visits/observation	✓		

35. See Evaluation Inception Report.

36. This was initially a country visit but was changed to desk review country in April 2019; see explanation provided.

Specific research tools utilized were:

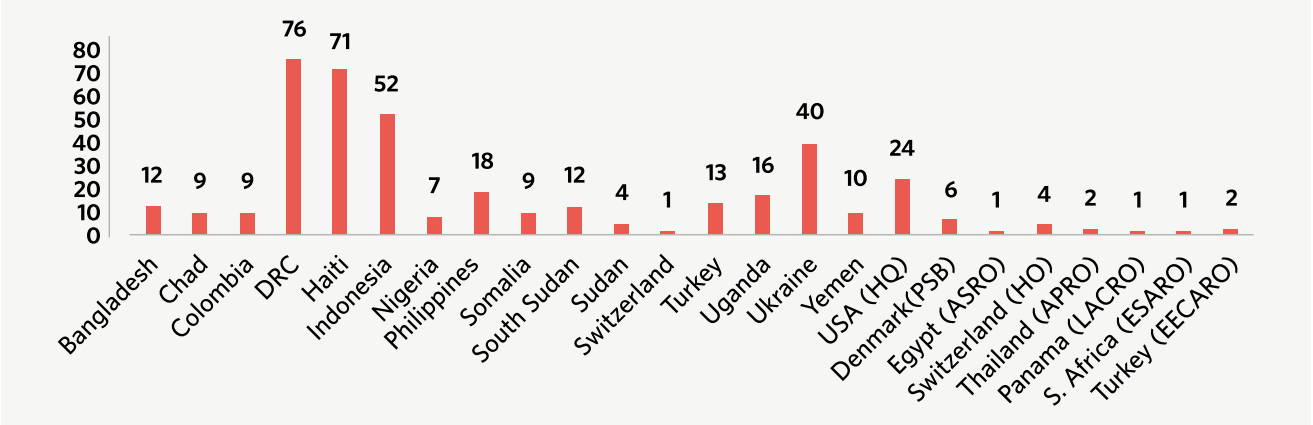
- Desk review of secondary documents and data (bibliography/sources in Annex Id)
- Collection of primary data via:
  - Key informant interviews (interview questionnaire in Annex Ia)
  - Focus group discussions (methodology in Annex Ib and details of stakeholder consultation process in Annex Ic)
  - Site visits/direct observation.

A total of 437 key informants and 150 current or past beneficiaries of UNFPA interventions were interviewed across all 15 participating countries and UNFPA regional and headquarters offices.

Disaggregation of key informants and focus group discussion participants and a full list of interviewees are presented in Annex Ia.

Guided by the evaluation matrix throughout data collection, the evaluation team engaged with a broad range of stakeholders, including implementing partner staff, UNFPA staff at headquarters, regional offices, sub-regional offices and country office levels, any regional hubs (depending on the field visit countries), other United Nations agencies (e.g., OCHA, UNICEF, UNHCR, WHO, among others), donors and the IASC cluster leads and coordinators, as well as additional duty bearers (both state and non-state actors), beneficiaries and service providers. Importantly, the evaluation team emphasized obtaining the views and understanding the experiences of community members and especially women and adolescent girls to ensure the findings were contextually grounded and the recommendations for future programming relevant.

FIGURE 3: *Key informant interviews by country*



SUMMARY OF MAIN LIMITATIONS AND MITIGATION MEASURES

A number of methodological limitations were identified during the inception phase. (For a full list of predicted and actual limitations, see Annex I.) The most significant limitations faced by the evaluation team were:

- Absence of a pre-existing comprehensive theory of change for programmatic interventions. This was anticipated as a significant limitation but proved not to be so because the reconstructed theory of change accurately represented the bulk of interventions carried out by UNFPA
- Length of time spent collecting data in countries, particularly for larger countries with extensive (and multiple) responses, e.g., DRC and Indonesia. This limitation was mitigated thanks to efficient evaluation team design and in-country scheduling
- Security/travel restrictions for Sudan. There was no alternative country that suited the sampling criteria for countries (and was feasible in logistical or security terms), hence the evaluation office determined that disruption to the data collection plan would be minimized by changing the status of Sudan from a field visit country to a remote desk review
- Shortage of quantitative outcome-related data. This proved a significant limitation for the evaluation – not just for the early elements (2012–2014), but for the entire evaluative time frame. This limitation has severely restricted the ability of the evaluation team to assess programmatic results and provide answers at the level of outcomes for evaluation question 4 (on effectiveness).

(c) UNFPA Yemen, Hodiedah Girls Foundation Hodeidah, Yemen

3 FINDINGS

EVALUATION QUESTION 1:
RELEVANCE/APPROPRIATENESS (ALIGNMENT WITH CHANGING NEEDS OF POPULATION)

To what extent does UNFPA humanitarian programming correspond to the changing needs of affected populations, while remaining aligned with the mandate and strategic direction of UNFPA?

FINDINGS

1. UNFPA humanitarian programming is well aligned with the specific humanitarian SRHR and GBV needs in different humanitarian contexts. This alignment is not a result of any organization-wide systematic mechanisms for ensuring relevance. There are no systematic or consistent mechanisms for assessing the needs of youth.

2. Across the sample of countries examined for this evaluation, there is evidence of an evolution of humanitarian response across different phases of a crisis, adapting to changing needs of affected populations.

3. The overall UNFPA capacity for humanitarian response has significantly and positively evolved from 2012 to 2019 to meet increasing humanitarian needs.

4. Gender and inclusion analysis within UNFPA programme design is neither consistent nor adequate.

5. UNFPA humanitarian programming remains aligned to the UNFPA mandate as articulated within the UNFPA Strategic Plans 2014-2017 and 2018-2021. This is explicit within humanitarian programming for SRHR and GBV but not for youth and data. There is less explicit reference to the second-generation humanitarian strategy which is itself outdated.

FINDING 1. UNFPA humanitarian programming is well aligned with the specific humanitarian SRHR and GBV needs in different humanitarian contexts. This alignment is not a result of any organization-wide systematic mechanisms for ensuring relevance. There are no systematic or consistent mechanisms for assessing the needs of youth. This evaluation noted strong evidence that regular and continuous assessments of needs are conducted and that responses are being adjusted resulting from identified needs. However, this is not achieved in all countries with the same degree of thoroughness or success and the evaluation noted an absence of corporate guidance in this area. There is evidence from across different responses of missed opportunities for synergy and thus duplication of effort within UNFPA in developing/implementing basic ap proaches, tools and processes.[37]

With respect to timeliness, examples from several country contexts demonstrate prompt needs assessments by UNFPA when crises occur:

In **Bangladesh**, UNFPA staff rapidly assessed needs around the escalating Rohingya refugee crisis in Cox's Bazar in August 2017. This was facilitated by both the UNFPA presence in Cox's Bazar (the centre of the refugee response) prior to escalation of the crisis in 2017 and the strengthening of humanitarian preparedness by the UNFPA Bangladesh Country Office. This comprised humanitarian training for staff and pre-positioning of RH kits for monsoon season, which were then utilized for the refugee response.[38]

In **Ukraine**, UNFPA has been consistently engaged in GBV assessments since the start of the conflict. In 2015, UNFPA commissioned research into GBV trends in govern-

37. Multiple UNFPA key informants across different country contexts. Refer to Annex V evaluation matrix EQ1A1.

38. For further information, refer to Annex V evaluation matrix EQ1A1.

ment-controlled conflict-affected regions[39] and used that evidence to quickly design a GBV programme tailored to the needs of internally displaced persons in these areas.[40]

In **Haiti**, UNFPA mitigates the prevalence of cyclical disasters and long-term development challenges via early assessments for GBV and SRHR after successive crises e.g., Hurricane Matthew (2016) and the October 2018 earthquake.[41]

Other countries where similar evidence was noted are **Philippines** and **South Sudan**.

The country-level evidence indicates that UNFPA conducts needs assessments within a similar timeframe as other United Nations agencies.[42] A key determinant is existing operational presence, with partners already undertaking humanitarian activities (such as operating health facilities) at the onset of a crisis that they can leverage for rapid action.

The evaluation noted a variety of **typologies of needs assessments**. Examples included instances of UNFPA conducting both standalone and joint needs assessments and those aimed at informing programme design and as ongoing monitoring exercises. Examples of different types of needs assessments are:

In **Indonesia**, UNFPA humanitarian responses (to frequent small natural disasters) are determined using a variety of methods for assessing needs of women, adolescents and youth, from early rapid assessments with government partners to more in-depth research among affected populations.[43]

In **South Sudan**, UNFPA produces regular situation reports with data on needs and services. Through the GBV sub-cluster, UNFPA supports its partners in undertaking periodic safety audits related to GBV. UNFPA South Sudan has also supported assessments of capacity needs of providers to improve training and other guidance for providers, particularly those working in the GBV one-stop centres and on reproductive health in the Protection of Civilian sites.[44]

UNFPA **Somalia** has contributed to and follows humanitarian needs assessments as identified within the Humanitarian Needs Overview (HNO), which is itself dependent on agency and joint assessments. From 2013 onwards, UNFPA has been involved in numerous inter-agency/OCHA-recorded assessments and appeals across the humanitarian response as reliable data sources.[45]

In the **DRC**, UNFPA-conducted assessments (either alone or jointly) have been used to design or revise projects. An example of such activity is the assessment mission coordinated by the GBV sub-cluster in May/June/July 2017 in Kasaï Central and Kasaï Oriental.[46] The assessment explored community perceptions of GBV, services available for psychosocial and legal support to survivors as well as medical attention and the challenges of collecting data on GBV in emergency situations.[47]

However, there is limited evidence of corporate support from UNFPA to country offices for these assessments. Country offices use different formats and tools for conducting assessments. There is a preponderance of focus on MNH, followed by GBV, with non-MNH sexual and reproductive health and rights receiving least attention. This results in a greater focus on MNH by UNFPA, specifically attention to basic and comprehensive emergency obstetric care (BEmOC and CEmOC) services rather than other aspects of SRHR such as family planning, access to safe abortion (where legal), sexually transmitted infections (STI) treatment and management (including HIV).

In some cases, e.g., **Ukraine** and **Colombia**, the absence of comprehensive SRHR needs assessment is due to a functioning state healthcare system, which provides some SRH services, with comparatively less attention to GBV needs. In these contexts reproductive health (or SRHR) working groups have not been established – SRHR considerations are folded into overall health needs assessments conducted by WHO (which leads the health clusters, where activated).[48] Such assessments routinely include MNH indicators, but not necessarily other aspects of SRHR (such as family planning, access to safe abortion (where legal) and HIV and STI treatment and management).[49]

The evaluation saw limited evidence of youth needs assessments. Some examples of this limited evidence are in **DRC**, where UNFPA conducted research on the vulnerability of adolescents in North Kivu in 2018.[50] In **South Sudan**, UNF-

39. Ukrainian Centre for Social Reforms. Gender-Based Violence in the Conflict-Affected Regions of Ukraine. Analytical report. 2015.
40. Multiple key informants.
41. For further information, refer to the Haiti country note and Annex V evaluation matrix EQ1A1.
42. Multiple internal and external key informants.
43. For further information, refer to the Indonesia country note and Annex V evaluation matrix EQ1A1.
44. For further information, refer to Annex V evaluation matrix EQ1A1.
45. Ibid.
46. UNFPA. Rapport Préliminaire : Évaluation de la situation et de la réponse aux violences basées sur le genre dans la crise du Kasaï. 2017. (Kasaï Central, Kasaï Oriental et Kasaï), mai-juillet 2017.
47. For further information, refer to DRC country note and Annex V evaluation matrix EQ1A1.
48. Note that the establishment of a reproductive health working group depends on WHO as well as the necessity of a working group vis à vis the functionality of the state health system.
49. For further information, refer to Annex V evaluation matrix EQ1A1.
50. Ibid.

PA reported a planned study on youth in 2019.[51] As part of their 2018 earthquake response in Central Sulawesi province, UNFPA **Indonesia** held focus group discussions with youth at camp level.[52] However, these are all ad-hoc and country-specific initiatives, with little evidence of needs assessments on youth being an agency-level responsibility based on global commitments that UNFPA has made.

FINDING 2. Across the sample of countries examined for this evaluation, there is evidence of an evolution of humanitarian response across different phases of a crisis, adapting to changing needs of affected populations. However, there is no systematic approach at country level to adapting to changing needs and, while there is strong evidence that this is happening in practice, respondents report each country is largely responsible for determining how to do this.[53]

For example, UNFPA **Yemen** has responded to a challenging context of multiple types of crises (conflicts, disease outbreaks and natural disasters). It has done so successfully by being an active participant in joint assessments since the conflict began and using joint platforms to adapt and improve programming. Since October 2018, UNFPA has led the Yemen rapid response mechanism which is specifically designed to respond immediately to rapidly changing needs across the country.[54]

In **Indonesia**, UNFPA translated its learning from its RH, GBV and youth response after the earthquake in Nusa Tenggara Barat (NTB) province in July 2018 to its response to the Sulawesi earthquake in September 2018, using lessons learned to significantly expand its work on GBV and youth, particularly through women- and youth-friendly spaces.

In **Bangladesh**, partners reported a continuum of improved response across phases:

In every step I see further improvement in partner management and focus moving from coverage to quality. Different indicators have been revised to give more focus on quality needs assessments. We now try to identify what are the lessons and gaps especially for service provision, equipment, privacy settings, infection prevention status, etc.[55]

Despite a considerable number of anecdotal examples of the progression of UNFPA programming in response to changing needs, the evaluation did not identify evidence of a systematic approach or institutional guidance for adapting a response to changing needs. Thus, while most countries can demonstrate a coherent adaptation process relevant to the context, country operations reported doing this with limited organization-wide guidance, or agency-facilitated learning from other country contexts about how to progress programming to meet changing needs.

FINDING 3. The overall UNFPA capacity for humanitarian response has significantly and positively evolved from 2012 to 2019 to meet increasing humanitarian needs. There is a clear consensus from evaluation respondents across country, regional and global levels, both internally and externally, that UNFPA humanitarian capacity has significantly improved over the last decade.[56] In 2015 (the earliest year for which data was available), the global UNFPA humanitarian spend was US$82,386,133.[57] In 2018, UNFPA received US$172,625,466 in humanitarian funding[58], which accounts for 31 per cent of total 2018 spend,[59] a near doubling of humanitarian activity in financial terms in just three years. This growth exists within the overall context of a scaling-up in international response to meet increasing humanitarian needs[60] but is also indicative of the evolution in scale of humanitarian action within UNFPA. Key policy and practice milestones in this timeframe include the second-generation UNFPA humanitarian strategy (2012);[61] the internal surge roster in 2014, the addition of an external roster (and with the first surge training including external candidates) in 2015.

These milestones triangulate with the evidence from evaluation respondents, many of which report an increased humanitarian capacity; for example:

Nine years ago, we had a limited humanitarian capacity … it has really been built and strongly supported by donors and partners. Eight or nine years ago, partners would say UNFPA is not a humanitarian actor, I think now we very strongly have positioned what we do as UNFPA in the humanitarian space.[62]

51. South Sudan UNFPA key informants. For further information, refer to Annex V evaluation matrix EQ1A1.
52. Indonesia UNFPA key informant. For further information, refer to Annex V evaluation matrix EQ1A1.
53. For further information, refer to Annex V evaluation matrix EQ1A1.
54. Ibid.
55. Bangladesh implementing partner key informant.
56. Multiple key informants at country, regional and global levels. For further information, refer to Annex V evaluation matrix EQ1A1.
57. UNFPA. Humanitarian Action 2016 Overview. 2016. https://www.unfpa.org/sites/default/files/pub-pdf/16-150_UNFPA_Humanitarian_2016_Overview_Final_Sheet_Final_Web_version.pdf
58. https://www.unfpa.org/data/dashboard/emergencies
59. The UNFPA 2018 spend is reported at US$550,052,707: https://www.unfpa.org/data
60. The United Nations has calculated global humanitarian requirements for 2019 of US$21.9 billon to reach 93.6 million people out of a total of 131.7 million people in need. This compares to the 2012 overview, which indicated a humanitarian aid volume of US$12.7 billion reaching 54 million people. OCHA. Global Humanitarian Overview, 2019. 2019 and OCHA. Global Humanitarian Overview, 2019. 2019.
61. UNFPA. Second Generation Humanitarian Strategy. 2012.
62. UNFPA key informant.

FINDING 4. Gender and inclusion analysis within UNFPA programme design is neither consistent nor adequate. Despite UNFPA application of the common IASC gender and age marker to projects funded through pooled funding mechanisms,[63] the evaluation found limited evidence of gender and inclusion analysis regularly informing UNFPA overall humanitarian responses and no evidence of a coherent organizational approach which could support country operations to ensure this.

The 2018 UNFPA Evaluation Office's Meta-Analysis of the Engagement of UNFPA in Highly Vulnerable Contexts did report that "...vulnerable population groups have been consulted as part of country programme design, either directly or through civil society representatives"[64], but this positive finding was one of the few pieces of evidence that attest to such inclusion.

The 2018 evaluation of the UNFPA Syria regional response noted sporadic but inconsistently documented examples of gender and inclusion analysis.[65] Similarly, this evaluation identified limited and ad-hoc examples of good practice.

In the **Philippines**, the UNFPA-led GBV task force conducted a 2017 analysis workshop of data collected for the GBV working group report on Marawi displacement on GBV and youth needs.[66] In 2012, UNFPA and other United Nations organizations supported a Philippines country gender assessment that included comprehensive gender analysis, also referencing issues affecting LGBT+ (lesbian, gay, bisexual, transgender and related communities) populations.[67]

In **Colombia**, UNFPA, OCHA and UN Women signed a joint plan of action in 2015 to incorporate gender perspectives into humanitarian settings, strengthen capacities in gender analysis and ensure that monitoring and evaluation included gender-specific indicators.[68]

In **Bangladesh**, UNFPA, UN Women and UNHCR plan to establish a gender hub by the end of 2019, which will provide support to strengthen gender and GBV analysis and mainstreaming.[69]

While these examples are promising, they are primarily instigated by the GBV sub-cluster or task force and do not demonstrate a consistent UNFPA global approach to gender and inclusion analysis within humanitarian response design and planning. GBV sub-clusters (or sector working groups, or task forces), despite being led by UNFPA, are standalone inter-agency entities and gender and inclusion strategies developed within these forums have not necessarily been applied across all UNFPA humanitarian programming areas.

Many UNFPA evaluation respondents reported that gender and inclusion are 'automatically' within UNFPA areas of responsibility – SRHR and GBV – and therefore inherent to programming. However, examples such as the Whole of Syria[70] GBV sub-cluster gender and inclusion analysis process highlight that simply focusing on women and girls without understanding the differentiated needs and vulnerabilities of different groups of women and girls is insufficient for a comprehensive response.

FINDING 5. UNFPA humanitarian programming remains aligned to the UNFPA mandate as articulated within the UNFPA Strategic Plans 2014-2017 and 2018-2021. This is explicit within humanitarian programming for SRHR and GBV but not for youth and data. There is less explicit reference to the second-generation humanitarian strategy, which is itself outdated. Alignment with the UNFPA strategic plans is typically explicitly articulated in-country programme documents (CPDs) or country programme action plans (CPAPs). Within humanitarian action, this alignment is often expressed implicitly through references to the UNFPA mandate rather than explicitly to strategic plan frameworks. This is also much clearer for SRHR and GBV than for youth and data, which are still areas of growth for UNFPA in humanitarian action. Examples include:

UNFPA **Somalia** promotes the MISP and provides GBV services in dedicated centres, implicitly aligned with both UNFPA strategic frameworks covering the evaluation period.[71] Evidence from UNFPA staff indicates clear recognition that the country programme is aligned to a rights basis within humanitarian response.[72] However, linkages are not made explicit in-country documentation (CPD/CPAP).

In **Uganda**, the 2010-2014 CPD noted plans to assist government progress toward MDG 1, 5, 6 and 7 and referenced the Programme of Action of the ICPD, the UNFPA Strategic Plan 2008-2013 and the Maputo Plan

63. The IASC gender and age marker has replaced the previous gender marker and is mandatory projects funded by pooled fund mechanisms such as the central emergency response fund or other country-based pooled funds. https://interagencystandingcommittee.org/other/content/iasc-gender-age-marker-gam-2018
64. UNFPA. Meta-Analysis of Engagement of UNFPA in Vulnerable Contexts. 2018.
65. UNFPA. Evaluation of the UNFPA response to the Syria crisis. 2019. https://www.unfpa.org/admin-resource/evaluation-unfpa-response-syria-crisis-2011-2018
66. Philippines key informants.
67. UNFPA. Philippines country gender assessment. 2012
68. United Nations Women. OCHA, ONU Mujeres y UNFPA Firman Plan de Acción Conjunto para Integrar Perspectiva de Género en Contextos de Respuesta Humanitarian. 23 April 2015. https://www.humanitarianresponse.info/fr/operations/colombia/article/ocha-onu-mujeres-y-unfpa-firman-plan-de-acci%C3%B3n-conjunto-para-integrar
69. United Nations. Joint Response Plan for Rohingya Humanitarian Crisis January-December 2019. Published in 2018.
70. The cross-border response from Turkey into Syria was included within this evaluation. However, this evaluation also draws upon the 2018 UNFPA Syria Regional Response evaluation: refer to https://www.unfpa.org/admin-resource/evaluation-unfpa-response-syria-crisis-2011-2018
71. Somalia key informants. For further information, refer to Annex V evaluation matrix EQ1A2.
72. Somalia UNFPA key informants. For further information, refer to Annex V evaluation matrix EQ1A2.

of Action.[73] The 2016-2020 CPD notes national plan and priority alignment, the United Nations Development Assistance Framework (UNDAF) 2016-2020 and the UNFPA Strategic Plan 2014-2017.[74] UNFPA interviewees reiterated the links, as well as with the existing Humanitarian Response Strategy.[75]

In **South Sudan**, the 2016-2017 CPD references the SDGs, the ICPD Programme of Action and the UNFPA Strategic Plan 2014-2017.[76] Further, a UNFPA informant reported that "the UNFPA strategic plans are the framework for all programming and all response plans are developed within this framework and aligned with the humanitarian strategy in these plans."[77] The 2016-2017 and 2019-2021 CPDs have four main outcomes: sexual and reproductive health and rights, adolescents and youth, gender equality and women's empowerment (including focus on GBV) and population dynamics, which are mainstreamed across all stages of UNFPA humanitarian response.[78]

The UNFPA second-generation humanitarian strategy does articulate an aspiration to "integrate gender and SRH issues into humanitarian programming by increasing awareness and commitment, enhancing capacity and strengthening partnerships with national entities, civil society, regional institutions and the international humanitarian system."[79]

However, there is less explicit reference to this strategy in the countries of focus for this evaluation. This can be partly ascribed to the fact that documented references within CPDs emphasize overarching internal and external frameworks, with the umbrella internal global framework under which UNFPA operates being the relevant-period strategic plan. However, respondents also reported limited reference to the second-generation humanitarian strategy due to the strategy being outdated. The second-generation strategy was launched in 2012, before improvements in surge, general humanitarian resourcing and commodity management;[80] before UNFPA assumed sole leadership of the GBV AoR (2016); and when, according to respondents, UNFPA was not yet considered a relevant, strong and capable humanitarian actor.[81] The overall context of humanitarian needs, UNFPA accountabilities, capacities and the recognition of SRHR and GBV as critical life-saving interventions within humanitarian action, all combine to indicate that a humanitarian strategy more relevant to the current context and to the reaffirmed commitment to humanitarian action by UNFPA senior management is required.[82]

73. UNFPA. Uganda Country Programme Document 2010-2014.
74. UNFPA. Uganda Country Programme Document 2016-2020.
75. UNFPA Uganda key informants. For further information, refer to Annex V Evaluation Matrix EQ1A2.
76. UNFPA. South Sudan Country Programme Document 2016-2017.
77. South Sudan key informant.
78. UNFPA. South Sudan Country Programme Document 2019-2021 and 2016-2017
79. UNFPA. Second-Generation Humanitarian Strategy. 2012.
80. Refer to the thematic papers on human resources for humanitarian action and supply-chain management for humanitarian commodities.
81. Multiple key informants. For further information, refer to Annex V evaluation matrix EQ1A2.
82. In 2019, UNFPA developed a vision paper to supersede the 2012 strategy. This is outside the 2012-18 scope of this evaluation and not discussed.

EVALUATION QUESTION 2:

Relevance/appropriateness (alignment with international law and principles)

To what extent does UNFPA humanitarian programming align with humanitarian principles, international humanitarian law, international human rights law, international refugee law and external direction of humanitarian action as framed by the Grand Bargain and the New Way of Working?

FINDINGS

6. The adherence of UNFPA to humanitarian principles is generally aligned with those specified in extant overarching humanitarian frameworks and, similar to other United Nations agencies, can be complicated by linkages with governments that are not compliant with these principles.

7. UNFPA has an inherent modality of working in close alignment with government partners, which reflects and reinforces the NWoW and thus supports progress in achieving the SDGs.

8. UNFPA has successfully promoted the global minimum standard for SRHR – the MISP – across all contexts. GBV standards are inconsistently understood and utilized across different contexts. There are no overarching common standards for working with and for young people.

FINDINGS 6. The adherence of UNFPA to humanitarian principles is generally aligned with those specified in extant overarching humanitarian frameworks and, similar to other United Nations agencies, can be complicated by linkages with governments that are not compliant with these principles. Humanitarian response is guided by four overarching and interlined principles of humanity, neutrality, impartiality and independence. These principles provide the 'foundations for humanitarian action'[83] and are formally enshrined in two General Assembly resolutions. Resolution 46/182 adopted in 1991 endorsed the principles of humanity, neutrality and impartiality. Resolution 58/114 adopted in 2004 added independence as the fourth key principle of humanitarian action.[84] These humanitarian principles are also enshrined in the Sphere Handbook.[85]

- **Humanity:** Human suffering must be addressed wherever it is found. The purpose of humanitarian action is to protect life and health and ensure respect for human beings.
- **Neutrality:** Humanitarian actors must not take sides in hostilities or engage in controversies of a political, racial, religious or ideological nature.
- **Impartiality:** Humanitarian action must be carried out on the basis of need alone, giving priority to the most urgent cases of distress and making no distinctions on the basis of nationality, race, gender, religious belief, class or political opinions.
- **Independence:** Humanitarian action must be autonomous from the political, economic, military or other objectives that any actor may hold with regard to areas where humanitarian action is being implemented.[86]

The evaluation gathered a range of examples of UNFPA staff reporting adherence to humanitarian principles primarily, or solely, through the overarching frameworks of the international humanitarian response. In **Nigeria**, UNFPA key informants reported adherence to humanitarian principles as laid out in successive HNOs and humanitarian response plans (HRPs).[87] This is in relation to targeting the most vulnerable (principle of impartiality), but UNFPA staff noted that strict adherence to this within humanitarian responses is frequently hampered by security/access constraints. In **Bangladesh**, the UNFPA Rohingya refugee response is aligned with the United Nations Joint Response Plan,[88] which itself is implicitly founded on humanitarian principles. However, nowhere in United Nations system-wide or UNFPA-specific documentation is the explicit reference to humanitarian principles for the Rohingya

83. OCHA. OCHA on message: Humanitarian Principles. https://www.unocha..org/sites/dms/Documents/OOM-humanitarianprinciples_eng_June12.pdf
84. Ibid.
85. https://spherestandards.org
86. OCHA. OCHA on message: humanitarian principles. https://www.unocha..org/sites/dms/Documents/OOM-humanitarianprinciples_eng_June12.pdf
87. For further information, refer to Annex V evaluation matrix EQ2A3.
88. Bangladesh key informants. For further information, refer to Annex V evaluation matrix EQ2A3.

refugee response.[89] In **Sudan**, UNFPA reports reference alignment with the current overarching humanitarian frameworks, which embody humanitarian principles.[90]

The evidence gathered indicates that, across all contexts, alignment with humanitarian principles is implicit rather than explicit and few UNFPA staff at any level could provide the evaluation team with examples of how UNFPA adheres to humanitarian principles, where the challenges are or how these challenges can be mitigated.[91] There is limited reference to humanitarian principles in any UNFPA documentation at country level. In the **Philippines**, UNFPA has a manual for reproductive health missions that explicitly references humanitarian principles in its guidance,[92] but this is the exception rather than the norm.

In some contexts, there is explicit reference to humanitarian principles within UNFPA-led GBV sub-cluster documentation and this is also the case for the GBV Area of Responsibility strategy, where the humanitarian principles are referenced as the operational principles guiding the collective.[93] For example, in **South Sudan**, the GBV sub-cluster strategy references and is guided by the Humanitarian Charter, the Core Humanitarian Standards and Sphere Protection Standards.[94]

Much humanitarian programming involves challenges in adhering to humanitarian principles. This is particularly true with respect to the principle of neutrality when maintaining close relationships with country governments that may be parties to internal conflict. Less egregious instances may occur where conservative social/cultural/religious trends have an impact on rights-based programming. Across a number of countries, respondents questioned the level of neutrality that can be achieved when close linkages with governments exist, particularly where humanitarian responses are strictly mediated through government.[95]

The balance of principles vs. access may provide a rationale for where UNFPA has been temperate in its advocacy and programming within development work; for example, on the issue of female genital mutilation (FGM), which is a component of its prevention of harmful practices initiative.[96]

For proper navigation of the challenges of principled humanitarian action, it is critical that all UNFPA staff at country level fully understand how these principles specifically apply to UNFPA response to humanitarian crises and the evidence from this evaluation suggests this is not fully the case. There is also no clear evidence that humanitarian principles are explicitly and consistently articulated in UNFPA programme documentation to ensure consideration of the principles and highlight challenges at design, implementation and monitoring stages.

FINDINGS 7. UNFPA has an inherent modality of working in close alignment with government partners, which reflects and reinforces the NWoW and thus supports progress in achieving the SDGs. One of the clear comparative advantages for UNFPA is close relationships with governments and this inherent approach is beneficial to positioning UNFPA favourably for working across the humanitarian-development continuum as embodied within the NWoW.

There is strong evidence across all countries of this evaluation to indicate that how UNFPA operates lends itself positively to the notion of collective outcomes – an essential element of the NWoW. For example, in **South Sudan,** UNFPA has a joint resilience programme explicitly linked with the NWoW under the Resident Coordinator's office.[97]

In **Yemen**, evidence from multiple respondents indicates that UNFPA is building the capacity of the Ministry of Health, building upon the existing structures and systems and thus linking to the NWoW and collective outcomes.[98]

In **Nigeria**, UNFPA works closely with existing public infrastructure and in close partnership with local and federal government, as well as community structures providing training of service providers, while also continuing to support government structures in longer-term development strategies.[99]

Despite these examples at country office level, the evaluation did not identify any evidence at a corporate level in relation to leveraging this comparative advantage specifically within the new humanitarian architecture. There is no extant global strategy for this.

89. Based on a review of overall response plans (2019,2018) and UNFPA documentation.
90. For further information, refer to Annex V evaluation matrix EQ2A3.
91. UNFPA key informants across all countries in this evaluation. For further information, refer to Annex V evaluation matrix EQ1A3.
92. UNFPA. A Manual on Organizing Reproductive Health Medical Missions in the Philippines. 2015.
93. https://gbvaor.net
94. GBV Sub-Cluster Strategy South Sudan, 2017
95. Ibid.
96. UNICEF (2016) reported that nearly half of girls under the age of 12 in Indonesia have undergone some form of FGM/cutting; see https://data.unicef.org/wp-content/uploads/country_profiles/Indonesia/FGMC_IDN.pdf
97. South Sudan key informants. For further information, refer to Annex V evaluation matrix EQ2A4.
98. For further information, refer to Annex V evaluation matrix EQ2A4.
99. Nigeria key informants. For further information, refer to Annex V evaluation matrix EQ2A4.

FINDINGS 8. UNFPA has successfully promoted the global minimum standard for SRHR – the MISP – across all contexts. GBV standards are inconsistently understood and utilized across different contexts. There are no overarching common standards for working with and for young people.

There is little disagreement in current international thinking that SRHR is a critical, central and foundational factor of equality and poverty eradication and must remain at the heart of development action.[100] However, SRHR as a key element of emergency response to disaster and conflict situations (SRHR in emergencies – SRHRiE) remains a less universally acknowledged priority.

In 2014, a global evaluation of SRHRiE by the IAWG highlighted many positive improvements over the preceding decade. Humanitarian funding for SRHRiE had increased from 2002 to 2013 to over US$2 billion. MNH was the best-funded component of the MISP, receiving 56 per cent of SRHRiE funding.[101] The evaluation reported the MISP being better-known in 2014 than in 2004, though it highlighted continuing gaps in delivery of the MISP, including limited focus on aspects of SRHR outside of MNH[102]. There is no compelling evidence from this evaluation to suggest that these gaps have been addressed.[103]

At the same time, the evaluation found consistent evidence across all contexts of a comprehensive understanding of the MISP by UNFPA staff, government partners, non-governmental organizations (NGOs) implementing partners and other United Nations agencies. A range of key informants across all stakeholder groups as well as secondary documentary data has attested to the significant and impactful role that UNFPA has played in this, including the provision of the MISP training[104] and incorporating MISP into national frameworks. For example, in the **Philippines**, UNFPA has provided policy advice, technical support and capacity building leading to the issuance of the National Policy on the MISP for SRH in Health Emergencies and Disasters[105] and in national and local disaster risk reduction (DRR) plans.[106]

In **Indonesia**, significant UNFPA advocacy and technical support to the Government resulted in the MISP being formally integrated into national guidelines in 2014/2015.[107] UNFPA subsequently undertook (and continues) widespread training on the MISP for midwives and support to strengthening the sub-national capacity on the MISP in disaster-prone regions and facilitating training of trainers in 2017, 2018 and 2019.[108]

In **DRC**, UNFPA has assisted the Government in the adoption of the MISP[109] into its own guidelines, entitled *Dispositif Minimum d'Urgence* (DMU). UNFPA DRC also supported peer-reviewed research on the use of the MISP and conclusions of that study emphasize that even basic training using the MISP improves outcomes for mother and newborn during delivery: "both the enhanced intervention group and the control group showed improvements over time following clinical training."[110]

Despite good examples of performance at national levels, there is no available documentary evidence of a global level understanding in UNFPA of the impact of increased awareness/knowledge of the MISP on SRHR outcomes in humanitarian settings, particularly for the more neglected components of MISP as highlighted by the IAWG evaluation (referenced above).

Global GBV standards are less consistently known and referenced than the MISP standards by UNFPA country offices. Of the various GBV guidance available, the IASC GBV guidelines were the most commonly referenced standards in the research countries. In the **Philippines**, UNFPA has supported uptake of the IASC GBV guidelines in the Marawi response.[111] In **Yemen**, UNFPA has provided funding for both the roll-out of the IASC GBV guidelines (2016) and

100. United Nations. Framework of Actions for the follow-up to the Programme of Action of the International Conference of Population and Development Beyond 2014.
101. IAWG. Taking Stock of RH in Humanitarian Settings – Key Findings from IAWG 2012-2014. 2015.
102. Long-acting methods include intrauterine devices (IUDs) and implants. Permanent methods include tubal ligation and vasectomy. Prior to 2018 FP was not a MISP objective but was an additional MISP key priority activity: – http://iawg.net/wp-content/uploads/2015/09/chapter7.pdf
103. For further information, refer to EQ2A5 and EQ4A8.
104. For further information, refer to Annex V evaluation matrix EQ2A5.
105. Government of the Philippines. DOH AO 2016-0005.
106. Philippines key informants. For further information, refer to Annex V evaluation matrix EQ2A5.
107. For further information, refer to Annex V evaluation matrix EQ1A5.
108. Indonesia key informants. For further information, refer to Annex V evaluation matrix EQ2A5.
109. See project "Advancing the evidence base of the Minimum Initial Service Package (MISP) for reproductive health: using a quality improvement approach in DRC" https://www.elrha.org/project/imc-misp-call2-2/ and the resulting publication Hynes et al., (2017) "Using a quality improvement approach to improve maternal and neonatal care in North Kivu, Democratic Republic of the Congo," Reproductive Health Matters, 25:51, 140-150. https://www.tandfonline.com/doi/pdf/10.1080/09688080.2017.1403276?needAccess=true
110. Ibid
111. Philippines key informants. For further information, refer to Annex V evaluation matrix EQ2A5.

for the GBVIMS.[112] In **Sudan**, UNFPA organized 2017 and 2018 REGA[113] visits to roll out the GBV guidelines.[114]

There is limited knowledge of the UNFPA Minimum Standards for GBV in Emergencies, launched in 2015. Evidence from respondents across multiple contexts suggests that these standards are not viewed as mandatory,[115] contrasting sharply with wide understanding of the MISP as mandatory minimum standards.[116] This is despite efforts from UNFPA headquarters including webinars and other trainings on GBV standards, with all GBV guidelines included within surge trainings. Some respondents identify the issue of broader GBV standards being less well-known and less referenced than the MISP being due to the underlying understanding within UNFPA that humanitarian action for UNFPA was limited to the MISP. It is noted that there is a sexual violence objective within MISP, but this is much more narrowly defined than GBViE within UNFPA.[117]

To date, there have been no common standards for working with and for young people in humanitarian action. However, in May 2019, UNICEF and the Norwegian Refugee Council released, under the auspices of the *Compact for Working with and for Young People in Humanitarian Action,* new guidelines for such work in humanitarian settings. It was too early for this evaluation to assess any traction that these guidelines will or may have among key stakeholders, including UNFPA.[118]

112. Yemen key informants. For further information, refer to Annex V evaluation matrix EQ2A5.
113. The REGA represent the GBV AoR and are an inter-agency resource available for country support missions within their regions of operation. They provide expertise and advocate for the recognition that GBV response and prevention is life-saving and that GBV programming is everyone's responsibility and needs to be addressed with adequate, comprehensive and coordinated action in humanitarian contexts. There are currently five REGA deployed around the world. http://gbvaor.net/who-we-are/regional-emergency-gbv-advisors-rega/
114. The overall goal of the guidelines is to support humanitarian stakeholders in fulfilling their responsibility to protect all those affected by crises, by reducing risk of GBV by implementing GBV prevention and mitigation strategies from pre-emergency to recovery stages of humanitarian action. https://gbvguidelines.org/en/
115. These standards are in the PPM and are considered mandatory by UNFPA headquarters.
116. Multiple UNFPA and other key informants. For further information, refer to Annex V evaluation matrix EQ2A5.
117. UNFPA headquarters key informants.
118. UNICEF and Norwegian Refugee Council. Guidelines for Working with and for Young People in Humanitarian Settings. 2019. https://reliefweb.int/report/world/guidelines-working-and-young-people-humanitarian-settings

EVALUATION QUESTION 3:
RELEVANCE/APPROPRIATENESS (ACCOUNTABILITY TO AFFECTED POPULATIONS)

To what extent does UNFPA humanitarian programming ensure that affected people (particularly women, adolescents and youth) are active agents in the design, implementation and monitoring of UNFPA and partners' activities and ensure that there is effective community engagement for the dissemination of information, participation, feedback and functioning complaints mechanisms, including for protection from sexual exploitation and abuse (PSEA)?

FINDINGS

9. There are many examples of accountability to affected populations (AAP) mechanisms in place to differing degrees across the sample of countries examined for this evaluation. However, these mechanisms have not been systematically incorporated within UNFPA programming. This has resulted in duplication of effort and missed opportunities for institutional synergy and consistency in approaching this important area. Knowledge of AAP across UNFPA staff – conceptually and pragmatically how to establish feedback mechanisms – is inconsistent.

10. UNFPA has significantly increased focus on PSEA at the corporate level, but this increased focus is recent and is only slowly filtering through the organization with knowledge of concepts and practices on PSEA currently remaining basic at the country level. UNFPA does not provide clear corporate guidance on the boundaries between GBV and PSEA.

FINDINGS 9. There are many examples of AAP mechanisms in place to differing degrees across the sample of countries examined for this evaluation. However, these mechanisms have not been systematically incorporated within UNFPA programming. This has resulted in duplication of effort and missed opportunities for institutional synergy and consistency in approaching this important area. Knowledge of AAP across UNFPA staff – conceptually and pragmatically how to establish feedback mechanisms – is inconsistent. UNFPA demonstrates differing levels of attention to AAP in different settings with no consistent institutional/global guidance to implement this. At country level, there is no minimum standard of knowledge of the principles of AAP or standardized methodologies for supporting implementing partners. There are many examples across countries of UNFPA staff, at the programmatic level, of seeking to ensure that feedback from communities and particularly women and girls, is incorporated into programme design, implementation and monitoring. However, this is not implemented in any coherent and systematic way.

In **Indonesia**, UNFPA undertakes regular activities to solicit input from affected populations. For example, for the response to the 2018 earthquake in NTB province, initial reproductive health assessments engaged local leaders in designing the response. Similarly, in the response to the 2018 Sulawesi earthquake, UNFPA and the Indonesian Ministry of Health met with community members early in the response.[119] UNFPA-supported research on youth-friendly services in Sulawesi used a participatory approach in which youth voices were captured and supported community members to be the data collectors.

This is also the case in the **Philippines**, where UNFPA ensures that women-friendly space (WFS) facilitators and GBV watch group members come from affected populations and are trained by their fellow facilitators/volunteers.[120]

In **Uganda**, respondents report ad-hoc processes for gathering beneficiary feedback and guidance to inform programming:[121] "We are mindful of the fact that we should interview both locals, nationals, refugees, but I wouldn't say for certain there is a system in place for this. We have an official and full field visit calendar and we have indicators to gather information on."[122]

In **Somalia**, AAP is not specifically noted in UNFPA documentation and there are no standardized methods of ensuring feedback. However, UNFPA partners are engaged in integrated community reproductive health using the Community's Own Resource Persons (CORPS) team, which includes men, religious leaders, village elders, chiefs, women group leaders, youth group leaders and community health workers. The team collects feedback, provides advice and, importantly, creates demand for UNFPA services.[123]

119. Indonesia key informants. For further information, refer to the Indonesia country note and Annex V evaluation matrix EQ3A6

120. For further information, refer to Annex V evaluation matrix EQ3A6.

121. Uganda UNFPA key informants. For further information, refer to Annex V evaluation matrix EQ3A6.

122. Ibid.

123. UNFPA Somalia. Independent Country Programme Evaluation 2011- 2015 (2016).

In **Sudan**, there is ad-hoc documentary reference to feedback processes across UNFPA programming, but none of systematic mechanisms being applied across the country programme. Examples of community feedback include designing hygiene kits on the basis of inputs from beneficiaries in a 2016 central emergency response fund (CERF) proposal for funding for RH and GBV prevention/response services[124] and community feedback on radio programmes addressing GBV to UNFPA staff via monitoring visits.[125]

Within the **Turkey** cross-border response, voices of women and girls are collected and communicated via both annual assessments and the Whole of Syria Voices report.[126] Due to the challenging nature of cross-border implementation of programming, UNFPA has invested heavily in feedback from women and girls across many locations, with information systematically analysed and triangulated.[127]

In **Yemen**, UNFPA partners must have feedback mechanisms in districts, with a national-level hotline for GBV under the GBV sub-cluster. Additionally, UNFPA works with a third-party monitoring partner for post-distribution monitoring and gathers feedback with respect to dignity/hygiene/mama kits distributed.[128]

For dignity kits particularly, evidence from multiple countries indicates that user feedback is solicited to adapt and contextualize kits (e.g., in **South Sudan**[129]). However, this feedback does not currently go beyond country level to tailor global standard dignity kits.

Despite the evidence of widespread ad-hoc AAP practices within UNFPA, there is no systematic institutional support from UNFPA headquarters to staff members to achieve this. The evaluation is cognizant that AAP is not meant to be prescribed or a 'one size fits all' approach and that different tools are relevant in different contexts. Nevertheless, there is currently no evidence of learning from different countries' experiences with regard to AAP or providing corporate guidelines for best-practice AAP solutions in relation specifically to GBV, SRHR and youth programming in different contexts. Further, respondents report that surge and humanitarian capacity trainings do not include sessions on AAP.[130]

AAP is increasingly being addressed under inter-agency initiatives, under either the Resident Coordinator/Humanitarian Coordinator's office or OCHA.[131] Evidence from senior transformative agenda implementation team (STAIT)[132] reports indicates gaps across all agencies in AAP, such as STAIT missions to Ukraine and Haiti in 2017, which noted need for improvements in AAP.[133,134] However, joint inter-agency efforts do not replace responsibility for ensuring effective AAP mechanisms are established for UNFPA programmes. At the global level, there was no evidence of consistent UNFPA engagement with the AAP and PSEA task team before 2018.[135,136]

FINDINGS 10. UNFPA has significantly increased focus on PSEA at the corporate level, but this increased focus is recent and is only slowly filtering through the organization with knowledge of concepts and practices on PSEA currently remaining basic at the country level. UNFPA does not provide clear corporate guidance on the boundaries between GBV and PSEA. In 2019, the United Nations Development Programme (UNDP), UNFPA and the United Nations Office for Project Services (UNOPS) jointly published an independent review of each organization's policies and procedures to tackle sexual exploitation and abuse (SEA) and sexual harassment.[137] The review reported that "even though UNFPA has launched many activities to ensure internal awareness, some interviewees said that there might generally be an issue related to the overall understanding of the SEA and sexual harassment terminology."[138,139] It further reported that new PSEA clauses have been inserted into UNFPA implementing partner agreements but "[a]s these contractual obligations

124. Application for CERF Funding: Essential emergency RH to vulnerable populations and prevention and response to GBV in support to South Sudanese refugees in White Nile State, 2016.
125. Final Report: Preventing and Responding to GBV amongst Vulnerable Migrants and Refugees in Sudan, 2017
126. UNFPA. Voices. 2018.
127. UNFPA, sister agency and sub-cluster/WG members' key informants. Also see Voices report as assessment end product.
128. For further information, refer to Annex V evaluation matrix EQ3A6.
129. South Sudan key informant. For further information, refer to Annex V evaluation matrix EQ3A6.
130. UNFPA regional key informants.
131. Multiple key informants and multiple humanitarian response planning documents.
132. STAIT was established to ensure the effective implementation of the Transformative Agenda from 2011: in 2017 the name was internally changed to peer-to-peer support project to reflect the changing humanitarian environment as articulated by the WHS and the Grand Bargain. However, humanitarian actors still refer colloquially to 'STAIT' missions and 'STAIT' reports. https://www.unocha..org/our-work/coordination/peer-2-peer-support-project
133. Ukraine UNFPA and other United Nations agency key informants.
134. UNFPA. Internal document: Haiti Humanitarian Coordinator Final Report December 2018. 2018.
135. https://interagencystandingcommittee.org/accountability-affected-populations-including-protection-sexual-exploitation-and-abuse
136. Task team meeting minutes, various – https://interagencystandingcommittee.org/accountability-affected-populations-including-protection-sexual-exploitation-and-abuse. Note that the UNFPA Coordinator for PSEA and SH started in mid-2018 and after this time, engagement increased.
Deloitte. Independent Review of UNDP, UNFPA and UNOPS Policies and Procedures to Tackle Sexual Exploitation and Abuse (SEA) and Sexual Harassment (SH). 2019.
137. Deloitte. Independent Review of UNDP, UNFPA and UNOPS Policies and Procedures to Tackle Sexual Exploitation and Abuse (SEA) and Sexual Harassment (SH). 2019.
138. Ibid.
139. Note that SEA refers to misconduct between a staff member and a community member while sexual harassment (SH) refers to misconduct within the workplace between employees.

are newly launched, the effect remains to be seen in practice."[140] This evaluation recognizes that many of the PSEA initiatives within UNFPA post-date this evaluation research, but show promise for more accountability related to PSEA.

In August 2018, UNFPA created a headquarters position for coordinator for PSEA and sexual harassment (SH). The coordinator sits within the office of the Executive Director and covers both development and humanitarian spheres and the position is aligned with the overall United Nations PSEA approach. The coordinator reports focusing on strategy implementation across UNFPA and ensuring coherence.[141]

UNFPA introduced mandatory online training for staff and consultants on PSEA in 2017. UNFPA has also provided webinars and face-to-face training during 2018 and 2019, including targeted sessions for high-risk operations. However, these trainings are not obligatory for other individuals working on behalf of UNFPA (who may have access to affected populations and their communities).[142]

In December 2018, UNFPA rolled out a focal point system to facilitate implementation of PSEA whereby all country and regional PSEA and SH focal points now have harmonized terms of reference. An initial workshop was conducted for regional office focal points focusing on their roles and responsibilities. In June 2019, a first three-day workshop was held for focal points from 25 of the highest-risk countries. A second workshop to cover an additional ten high-risk countries was planned for September 2019.[143]

At country level, PSEA focal points are responsible for conducting individual training sessions as part of 2019 country-level work plans.[144] UNFPA has also developed partner training modules[145], but not all countries have rolled out this training.[146]

UNFPA also includes a PSEA clause within implementing partner agreements, but the evaluation found no evidence of comprehensive follow-up at country level. While some partners, such as in Indonesia, reported an understanding of the PSEA clause, others were unaware of it.[147]

The evaluation research also identified evidence of UNFPA implementing additional PSEA policies and systems (such as for reporting internally and/or externally, survivor assistance policies and investigation and disciplinary policies[148]). Notably, UNFPA has clear policies and pathways for internal reporting, but these have limited visibility at country level. For example, UNFPA has published an overview of internal mechanisms for staff to report wrongdoing[149], but this was not referenced by any respondent at country level across the research countries.

In some contexts, UNFPA leads joint AAP and PSEA task forces. For example, in **South Sudan**, UNFPA and UN Women co-chair the PSEA Task Force and community-based complaints mechanisms are being implemented countrywide.[150,151] In **Nigeria**, UNFPA, via GBV sub-sector partners, developed a 2018 interagency community-based complaint mechanism for SEA and PSEA workshops and trainings have been taking place since 2017.[152] Respondents report that the coordination between agencies in terms of referrals for services is an effective method for ensuring the protection of survivors and witnesses but that comprehensive PSEA mechanisms are yet to be properly rolled out.[153]

In **Indonesia**, UNFPA has allocated 25 per cent of a GBV specialist's time to PSEA and has undertaken to lead the PSEA training of United Nations actors at the national level, by 2019 conducting sensitization among 100 individuals representing 40 institutions. In 2018, UNFPA also issued draft standard operating procedures and guidelines on PSEA for all United Nations agencies. At the behest of the humanitarian country team (HCT), UNFPA co-leads the PSEA focal point network with UNICEF in Central Sulawesi.[154]

140. Deloitte. Independent Review of UNDP, UNFPA and UNOPS Policies and Procedures to Tackle Sexual Exploitation and Abuse (SEA) and Sexual Harassment (SH). 2019.
141. UNFPA key informant. See https://www.un.org/preventing-sexual-exploitation-and-abuse/
142. For example, the members of this evaluation team were not asked to undertake the PSEA training, despite having direct access to women and girls in a number of contexts.
143. UNFPA headquarter key informants.
144. As this is a recent (2019) initiative the evaluation was unable to verify how it was implemented and rated within performance workplans. Further, no PSEA focal points were available to provide information across the countries included within this operation.
145. UNFPA headquarters key informants.
146. Multiple UNFPA, other United Nations and NGO key informants. For further information, refer to Annex V evaluation matrix EQ3A7.
147. For further information, refer to the Indonesia country note and Annex V evaluation matrix EQ3A7.
148. See PSEA task force for the four pillars of a comprehensive PSEA practice including prevention (of which training is one part); response; management and coordination; and engagement with local populations. http://www.pseataskforce.org/en/addressing_it
149. UNFPA. Overview of Mechanisms for Reporting Wrongdoing at UNFPA. https://www.unfpa.org/sites/default/files/admin-resource/2018-02_Overview_of_mechanisms_for_Reporting_Wrongdoing_at_UNFPA.pdf
150. In-Country Task Force on PSEA. Terms of reference on In-Country Task Force for PSEA – Terms of Reference, February 2016.
151. UNFPA key informant.
152. Nigeria key informants. For further information, refer to Annex V evaluation matrix EQ3A7.
153. Ibid.
154. Indonesia UNFPA key informants. For further information, refer to the Indonesia country note and Annex V evaluation matrix EQ3A7.

Similarly, in the **Philippines** and **DRC**, the UNFPA GBV specialists have co-led the PSEA Task Force and supported (through the GBV coordination mechanism) capacity building of partners on PSEA.

Notwithstanding these efforts to move the PSEA agenda forwards, global UNFPA guidance on GBV coordination is clear that GBV coordinators should not take up leadership of PSEA.[155] However, this technical guidance is not reflected in corporate guidance. The evaluation noted confusion around the links and distinctions between GBV and PSEA work at country level.[156] While many acts of SEA against women and girls constitute GBV, protection from SEA (because acts of SEA are committed by humanitarian actors rather than members of the affected community) is management of AAP. The responsibility to ensure PSEA systems are in place across the response lies with the Resident Coordinator/Humanitarian Coordinator (RC/HC) and, at the agency level, with the UNFPA Country Representative. The evaluation identified several instances where UNFPA staff were not clear on the delineation between the two, including among GBV specialists/coordinators.[157,158]

In 2017 UNFPA produced a briefing paper[159] stating:

"... it is critical to note that SEA is not exclusively under the purview of GBV specialists or GBV specialized agencies and... the responsibility to protect lies with the humanitarian community at large; future reporting...should reflect this."[160]

Overall, evaluation evidence suggests that, while significant efforts have been made to improve the overall PSEA approach within UNFPA, it is too early to systematically observe a discernible country-level impact.

155. UNFPA. GBV AoR. Handbook for Coordinating Gender-Based Violence Interventions in Emergencies. 2019
156. UNFPA and other key informants. For further information, refer to Annex V evaluation matrix EQ3A7.
157. Multiple UNFPA key informants. For further information, refer to Annex V evaluation matrix EQ3A7.
158. The UNFPA GBV team and the GBV AoR have collaborated on guidance on PSEA to GBV coordinators which has been included in the GBV coordination handbook launched in 2019.
159. UNFPA. Gender-Based Violence in Emergencies; Analytical Paper on WHS Self-Reporting on Agenda for Humanity Transformation. 2017. https://www.agendaforhumanity.org/sites/default/files/resources/2018/Jul/Analytical%20Paper_2D_GBV_Final_26%20July.pdf
160. Ibid.

EVALUATION QUESTION 4:
EFFECTIVENESS

To what extent is UNFPA achieving its objectives in terms of humanitarian action?

FINDINGS

11. Across the sample of countries examined for the evaluation, there is evidence of clear output-level results of maternal and newborn health services, but less evidence of results for the whole spectrum of SRHR services supported by UNFPA. There is also less evidence of consistent GBV service-delivery effectiveness. Youth programming (not coordination) is increasing, but still nascent, with examples across most countries of increased consideration for youth-friendly/adolescent-friendly services but with limited evidence of results.

12. Awareness-raising and social norms change is limited within a UNFPA humanitarian response compared to service-delivery results and monitoring of effectiveness is hampered by the absence of comprehensive humanitarian-specific outcome-level indicators.

13. At the global level, both SRHR and GBV responses have become increasingly considered as life-saving within humanitarian interventions since 2012. For SRHR, this is still primarily limited to maternal and newborn health services. At country level, there has been mixed success in terms of UNFPA advocacy within the broad humanitarian community (United Nations agencies, donors and NGOs, among other humanitarian actors) to ensure the SRHR and GBV response is understood as life-saving, but there is clear success with host governments across different contexts.

14. UNFPA inconsistently leverages population data for informing overall humanitarian responses.

15. UNFPA data systems are not adequate for monitoring outcome-level humanitarian results.

16. There are many examples of UNFPA increasing resilience through working with service providers at the facility level or with government at the national level, but limited evidence of UNFPA programming changing resilience at individual or community level.

Note for Evaluation Question 4: UNFPA does not have mechanisms in place to monitor or report on meaningful outcome-level results within humanitarian response. Within humanitarian datasets, output or activity-level results are captured consistently, with outcome-level (effectiveness) data only sporadically available. Therefore, the effectiveness findings are framed within this limitation. Please see further information under findings 10 and 13.

FINDINGS 11. There is evidence across all countries of clear output-level results of maternal and newborn health services, but less evidence of results for the whole spectrum of SRHR. There is also less evidence of consistent GBV service-delivery effectiveness. Youth programming (not coordination) is increasing, but still nascent, with examples across most countries of increased consideration for youth-friendly/adolescent-friendly services.

UNFPA has data to demonstrate results at activity and output level (such as number of dignity kits distributed or number of individuals trained on the MISP), which provide a limited basis for reporting results. Beyond this, UNFPA does not consistently collect standardized outcome-level results data. A summary of specific challenges related to data identified by the evaluation is presented in the following table.

TABLE 3: *Table of data challenges within UNFPA humanitarian operations*

Challenge	Examples and explanations
Data is primarily activity-level results, mixed with output-level results	**DRC**: results data made available include 83 health providers and other actors trained on the MISP/3 community-based radios broadcast (activity-level results), combined with 17,724 women receiving antenatal care; 7,822 safe deliveries; and 185 rape survivors receiving medical care (output-level results). **Bangladesh**: results data made available include 144 personnel trained on EmOC, 291 personnel trained on clinical management of rape (CMR), 251 personnel trained on the MISP (activity-level results), with 36,039 people reached with SRH services (output-level results, but meaningless when consolidated).
Data is inconsistent across duration	**DRC** provided data for Kasaï for October and November 2017 and for Tanganyika province from July to November 2017. **Bangladesh** data from escalation of the Rohingya crisis, August 2017 to December 2018. **Turkey** provided data from the start of the refugee crisis in 2011 to April 2019.
Data is presented as vague and sometimes meaningless data sets	E.g., "Affected population who directly benefited from all types of emergency RH kits" and "Women and girls accessing services provided through Service Delivery Points (SDPs) that are equipped with Post-Rape Kits."[161] It is unclear for the first dataset whether country operations actually calculate the number of people who access RH supplies through a clinic equipped with RH kits or whether this figure is simply calculated from the number of people a kit is designed to reach across a given period of time. Further, it is not specified whether this is calculated as the number of individuals benefitting (i.e., one pregnant woman) or the number of services being accessed (i.e., one pregnant woman accessing four antenatal care visits and a safe delivery visit equally five distinct services). For the second data set, it provides no information about how many women and girls actually access post-rape services or supplies.
A shortage of target or denominator for results	No country participating in this research provided activity or output-level results data against comprehensive targets (across a response, as opposed to project targets provided to donors within a specific geographical and temporal-targeted project).

These limitations notwithstanding, some outcome-level quantitative and qualitative evidence (obtained by the evaluation via direct testimony of stakeholders, including community-level beneficiaries and via secondary reporting) attests to positive results of UNFPA humanitarian action.

Across all contexts, UNFPA supports MNH services to women and girls which would otherwise not be available. In **Indonesia**, the considerable investments of UNFPA in capacity building and policy development have contributed to ensuring that quality MISP-related services are available when disasters strike. As a result of this support, in response to the 2018 NTB province earthquake, UNFPA facilitated 345 safe deliveries between August and December 2018 (with zero maternal deaths). For the three months after the Sulawesi earthquake in September 2018, UNFPA recorded 277 safe deliveries (again, with zero maternal deaths).

Findings from satisfaction questionnaires administered among community members were that 96 per cent of beneficiaries felt the services were good or very good.[162]

In **Somalia**, UNFPA annual reports covering the years 2016-2018 demonstrate that UNFPA worked with national partners to strengthen both BEmOC and CEmOC[163] centres and created an important niche through training health personnel. UNFPA also provided equipment, supplies and ambulances to support emergency referrals. During 2017, UNFPA reported 9,500 safe deliveries in UNFPA-supported centres.[164] During 2018, UNFPA reported 37,963 safe deliveries in supported centres.[165]

In many contexts, UNFPA contributes to effective SRHR response through training support to midwives across a

161. See any available data on a country UNFPA transparency portal website such as: https://www.unfpa.org/data/transparency-portal/unfpa-haiti

162. UNFPA Central Sulawesi Infographic.

163. In Somalia, BEmOC and CEmOC are, respectively, referenced as basic emergency obstetric and newborn care (BEmONC) and comprehensive emergency obstetric and newborn care (CEmONC).

164. UNFPA. Somalia Annual Report. 2017.

165. UNFPA. Somalia Annual Report. 2018.

suite of SRHR services and even basic GBV psychosocial support (PSS) and referral to other GBV services. In **South Sudan**, UNFPA implemented a project to deploy midwives and dignity kits across ten states.[166] UNFPA is the sole supplier of family planning and contraceptives in both the humanitarian and non-humanitarian context. According to one UNFPA respondent, "we've seen increased utilization [and] uptake of family planning for women, all within the humanitarian context."[167]

In **Yemen**, UNFPA supported midwife training between 2012 and 2015 (until the 2015 conflict started). As of 2019, UNFPA continues to provide performance-based payments to the trained midwives for provision of free services to end-users and reported to work with the Ministry of Health for task-shifting, allowing midwives to provide more services at community level.[168]

In **Haiti**, UNFPA supports midwives in delivering integrated services through both facilities and outreach (mobile clinics and home visits) and across 'normal' development and humanitarian response contexts. The majority of evidence from relevant respondents indicated that the UNFPA strategy to expand the pool of skilled midwives through the development sphere – both in terms of increasing the number[169] and improving the quality of training, including emergency response training – is an effective strategy to increase access to emergency SRHR services in times of crisis by various stakeholders.[170]

BOX 2: OBSTETRIC FISTULA IN HUMANITARIAN SETTINGS

Obstetric fistula, one of the most serious and tragic childbirth injuries, is not specifically referenced in the MISP,[171] but is a major cause of maternal mortality and morbidity, particularly for adolescent girls and young women. It is a concern for all development settings and a humanitarian concern when a humanitarian crisis leads to reduced access to contraception resulting in higher numbers of pregnancies; increased child marriage resulting in higher numbers of adolescent pregnancies; and reduced access to quality EmOC services, resulting in higher risk of mortality and morbidity during childbirth. UNFPA has many examples of fistula initiatives in its humanitarian programmes.

In **Yemen**, UNFPA established two fistula centres in 2010 to address the estimated 8,000 cases per year but, since the war started, these have received reduced funding because they are not considered emergency response priorities. Between 2014 and 2017, 261 fistula repair surgeries were supported by UNFPA.

In **Uganda**, UNFPA began its national fistula campaign in 2003 alongside the Ministry of Health in support of prevention and treatment. UNFPA reported in 2016 that it trained six of the 24 fistula surgeons in the country in advanced fistula repair and that it supported 64 fistula camps. A total of 1,501 women accessed support for repair. In 2017, Uganda experienced 1,900 new cases of fistula.

In **South Sudan**, approximately 100 women receive fistula treatment service through UNFPA services each year.

In **Nigeria**, UNFPA supported capacity development for 13 specialist surgeons for fistula in 2018 and seven resident gynaecologists who developed basic level skills, through participation in clinical review meetings and exposure to fistula surgery. UNFPA further developed the capacity of 33 social workers in fistula cases. UNFPA supported free surgeries for 335 beneficiaries and worked with 219 fistula survivors who participated in skill acquisition and social reintegration programmes.

In **Bangladesh**, UNFPA provided support to the Hope Foundation, which performed 100 fistula surgeries in 2018, with more than 70 of those patients being Rohingya refugees.

166. https://reliefweb.int/report/south-sudan/south-sudan-camp-midwifery-training-offers-crucial-lifeline

167. South Sudan UNFPA key informants. For further information, refer to Annex V evaluation matrix EQ4A8.

168. Within a remote extended desk review, it is not possible to clearly determine the implementation and impact of this training.

169. As of early 2019, Haiti had approximately 400 active public sector midwives and a need for 2,200 to meet demand. For further information, refer to the Haiti country note.

170. Multiple key informants. For further information, refer to Annex V evaluation matrix EA4A8.

171. Note that there is a reference to obstetric fistula in the revised 2018 IAFM. http://iawg.net/iafm/

For GBV services, there is good qualitative evidence that UNFPA support has led to increased quantity and improved quality. However, robust and consistent quantitative data on GBV-related outcomes is limited to activity and output-level results, is inconsistent across geography and duration and is frequently missing measurable targets or denominators for determining results on populations. The limited available evidence suggests that different approaches have led to various degrees of effectiveness. One widespread approach is the delivery of GBV services and referrals through a women-friendly space, a female-friendly space, or a women and girls safe space (WFS, FFS and WGSS, respectively).

In **Bangladesh**, UNFPA funds 20 WFS with coverage of 50 per cent of the existing Rohingya refugee camps and associated host communities through which an estimated 65 per cent of affected women and girls have access. It is estimated that each WFS averages 100 visitors daily but does not track new versus repeat visitors. Further, data on the impact of the WFS activities and referral mechanisms on the health and well-being of women and girls is limited to anecdotal partner reports.

In **Nigeria**, UNFPA supports 30 safe spaces for women, girls and youth that provide PSS, skills for economic empowerment and contain a social and community networking component. However, there is no detailed data on the number of women, girls and youth who have benefited nor related outcomes.

In **Turkey**, as of April 2019, UNFPA-supported facilities (WGSS and youth centres established from 2015 onwards) had provided services to 418,305 beneficiaries for GBV services, including PSS and empowerment activities. The impact of these services on the health and well-being of women and girls is not measured.[172] In **Somalia**, UNFPA supports a total of 13 one-stop centres and reaches a total of 157,001 persons (30,966 girls; 17,664 boys; 87,098 women; and 21,273 men) at the sub-sector level.[173]

In **Ukraine**, there is clear evidence of the effectiveness of mobile PSS teams, operational since 2015, at increasing access to comprehensive GBV services.[174] Between 2015 and 2018, PSS mobile teams responded to 40,388 GBV cases – 89 per cent women and girls and 29 per cent internally displaced persons. For 64 per cent of the survivors accessing support through this programme, the PSS mobile teams are the first people from whom survivors have sought help.[175]

Two key pieces of evidence highlight effectiveness of the PSS mobile teams: firstly, numbers of survivors reporting to the PSS mobile teams and seeking support and assistance have generally risen consistently each year. Secondly, GBV reporting in areas where PSS mobile teams operate is overall significantly higher than in those areas where there are currently no PSS mobile teams.

In relation to youth services, the evaluation has identified some examples of UNFPA-supported youth programming but with similar absence of outcome-level data as the SRHR and GBV services.

In **Turkey**, UNFPA supports four youth centres for broad services for youth, but no evidence or robust data on the impact of these youth centres on youth was available.

In **Indonesia**, respondents reported that youth were given a formal voice in emergency response[176] and being considered in delivery of RH services – a challenging issue, given the conservative social environment.

In **South Sudan**, the UNFPA adolescent and youth programme supported training of 26 teachers on comprehensive sexuality education and 63 health care providers on provision of youth-friendly services resulting in 200,000 adolescents and youth accessing these services.[177]

In **Haiti**, UNFPA began to engage with the national youth platform in 2018 and supported preparedness plans for humanitarian action but this work is ad hoc, inconsistent and nascent.[178]

In the **Philippines**, UNFPA considers youth engagement to be crucial for responding to ongoing long-term threats from natural disasters.[179] Since 2014, UNFPA has supported work with youth networks to engage young people in emergency response and connect to longer-term development. UNFPA has supported mobile youth volunteer teams to deliver information on RH services, distribute dignity kits and reach out to peers on SRH and GBV. However, there is no clear evidence of outcomes of the activities.

FINDINGS 12. Awareness-raising and social norms change is limited within a UNFPA humanitarian response compared to service-delivery results and monitoring of effectiveness is hampered by the absence of comprehensive humanitarian-specific outcome-level indicators. Evaluation evidence indicates that UNFPA humanitarian responses generally focus on service delivery rather than

172. For further information, refer to Annex V evaluation matrix EQ4A8.
173. UNFPA. UNFPA Annual Report, 2018.
174. Multiple Ukraine key informants and UNFPA RFQ: UNFPA/UKR/RFQ/18/12 Evaluation of UNFPA psychosocial support to survivors of gender-based violence in Ukraine through PSS mobile team model. October 2018. For further information, refer to the Ukraine country note.
175. UNFPA RFQ: UNFPA/UKR/RFQ/18/12 Evaluation of UNFPA psychosocial support to survivors of gender-based violence in Ukraine through PSS mobile team model. October 2018. For further information, refer to the Ukraine country note.
176. Indonesia key informants. For further information, refer to the Indonesia country note and Annex V evaluation matrix EQ4A8.
177. UNFPA. South Sudan Country Programme Document 2016-2017. 2016.
178. Haiti key informants. For further information, refer to the Haiti country note and Annex V evaluation matrix EQ4A8.
179. For further information, refer to Annex V evaluation matrix EQ4A8.

awareness-raising or fostering social norm changes on women's rights and the prevention of GBV.[180] However, given the long-term nature of many of the crises UNFPA responds to, changes in social norms are critical components of an effective response. Overall, UNFPA focuses on awareness-raising activities conducted through WFS or similar platforms and tends toward traditional methods of engagement rather than using new, research-informed and peer-reviewed approaches to social norms change, such as SASA!, which UNFPA utilizes in development settings.[181]

As with other areas, there is little evidence of UNFPA conducting longer-term systematic monitoring of effectiveness or impact of awareness-raising activities for the prevention of GBViE.[182] The evaluation did gather, however, some limited qualitative evidence of the effectiveness of supported interventions in participating research countries.

In **Bangladesh**, UNFPA funds approximately 350 community health workers who conduct door-to-door visits to women and girls (many of whom are culturally restricted from travelling outside their homes) to inform them of services and of their right to access these services. Respondents report anecdotally of changes in the behaviour of Rohingya refugee women – greater confidence in asking questions with regard to services they can access, as well as speaking more openly about GBV issues within the community.[183]

In **Somalia**, UNFPA has focused on raising awareness of the effects of FGM and early marriage on maternal mortality and morbidity, advocating for the implementation of laws prohibiting FGM.[184] UNFPA utilized radio and TV spots, theatre performances, sports and social media to advocate on the above themes and also supported outreach to youth through school clubs. Across the years 2016 to 2018, either the Somalia GBV sub-cluster report or the Somalia UNFPA annual report has reported a number of community declarations on the intent to abandon FGM.[185]

In Haiti, there is limited but increasing UNFPA support to programming around awareness-raising activities and norm change (including with adolescent girls). However, the 2013-2016 country programme evaluation noted that the UNFPA Haiti theory of change had no explicit link between activities, outputs and impact. In particular, the evaluation noted that "UNFPA has not specifically mobilized advocacy to advance the outdated legislative framework, including mobilizing partners with a message on the equal rights of adolescent girls and similarly for abortion."[186]

While UNFPA **Haiti** has a strategy of utilizing community-based midwives for the provision of services and awareness-raising of harmful social norms and attitudes, the latter component has not been as successful as the former, given the continuing prevalence of high tolerance of violence toward women and girls. Since 2017, a GBV module designed with the help of UNFPA has been included within midwifery training, but evidence from key informants indicates that there is very limited understanding of the dimensions of GBV in Haiti (e.g., intimate partner violence) and harmful social norms around GBV are not changing.[187]

In **South Sudan**, UNFPA has undertaken considerable work on community awareness-raising on GBV through outreach, radio programs and information, education and communication materials. However, as with other countries, there is little or no evidence of the effectiveness of this approach. The South Sudan joint programme on GBV includes a pillar on social norms change, anticipated by stakeholders to support more rigorous prevention efforts.[188]

In **Ukraine**, UNFPA has demonstrably contributed to effective and significant continuous positive change with regard to attitudes toward GBV. UNFPA has very successfully leveraged the humanitarian crisis to increase awareness of GBV in Ukraine. The 2015 Ukrainian Centre for Social Reforms report highlighted that "[t]here is no common practice to seek assistance from specialized institutions in cases of violence."[189] In addition to establishing the PSS mobile teams – with the Government of Ukraine planning to adopt the model countrywide – UNFPA has supported awareness-raising activities on GBV since the start of the conflict. Most stakeholders in Ukraine reported that these awareness-raising activities have contributed to GBV receiving more attention within Ukraine – both in the conflict-affected regions and elsewhere and from both government and the public – than ever before.[190]

180. For further information, refer to Annex V evaluation matrix EQ4A9.
181. 'Sasa' is a Kiswahili word meaning 'now.' The SASA! approach is based on addressing the core driver of violence against women and HIV: the power imbalance between women, men, boys and girls. SASA! is a whole community approach (as opposed to an out-dated "engaging men and boys approach") focusing on unpacking power, both in its positive and negative manifestations and using this to reshape social norms. http://raisingvoices.org/sasa/
182. For further information, refer to Annex V evaluation matrix EQ4A9.
183. Bangladesh key informants. For further information, refer to Annex V evaluation matrix EQ4A9.
184. UNFPA. Somalia Country Programme Evaluation 2011-2015. 2016
185. UNFPA. Somalia Annual Report. 2018. Also, untitled GBV sub-cluster report. UNFPA, 2016.
186. UNFPA. 2013-2016 Country Programme Evaluation. 2016.
187. Haiti key informants. For further information, refer to the Haiti country note and Annex V evaluation matrix EQ4A9.
188. For further information, refer to Annex V evaluation matrix EQ4A9.
189. Ukrainian Centre for Social Reforms. Gender-Based Violence in the Conflict-Affected Regions of Ukraine. Analytical Report. 2015.
190. Multiple Ukraine key informants. For further information, refer to the Ukraine country note and Annex V evaluation matrix EQ4A9.

Conflict was the reason for us to enter into this topic of GBV.[191]

Normally traditionally we don't speak about private matters outside of house, but this has really changed now, women shouldn't hide these facts and this is now a big result.[192]

FINDINGS 13. At the global level, both SRHR and GBV responses have become increasingly considered as life-saving within humanitarian interventions since 2012. For SRHR, this is still primarily limited to maternal and newborn health services. At country level, there has been mixed success in terms of UNFPA advocacy within the broad humanitarian community (United Nations agencies, donors and NGOs, among other humanitarian actors) to ensure the SRHR and GBV response is understood as life-saving, but there is clear success with host governments across different contexts. Respondents to this evaluation at country, regional and global levels all reported that SRHR (although, specifically the maternal and newborn health component of SRHR) and GBV are now considered to be life-saving interventions within humanitarian response – a significant change from a decade ago.[193]

Notwithstanding this positive change, maternal and newborn health (limited to emergency obstetric care and newborn care) has always been considered a life-saving priority in emergencies under WHO-led health sector responses. For example, while the MISP is first referenced in the Sphere Handbook in 2004 under "Health Action," maternal mortality is embedded throughout the Sphere standards of nutrition and health and within mortality and morbidity surveillance criteria.[194] There is limited evidence to suggest other aspects of SRHR (HIV/STIs, contraceptives access) are considered more life-saving in 2019 than a decade prior.[195]

There is clear and consistent reference to GBV within humanitarian response plans and humanitarian needs overviews.[196] However, as highlighted by the 2019 Oslo conference on Ending Sexual and Gender-Based Violence in Humanitarian Crises, this increased visibility and rhetoric has not translated into increased commitment or impact.[197]

However, testimony of respondents suggests that, while increased visibility of GBV in humanitarian action has not necessarily resulted in adequate GBV programming, there has been an increase of GBV attention and accountability within humanitarian action over the period of this evaluation.[198] This is despite the fact that GBV remains one of the most underfunded sectors of humanitarian response – between 2016 and 2018 GBV-specific funding amounted to 0.12 per cent of all humanitarian funding, one-third of that requested.[199]

UNFPA, with other actors, has contributed to this improvement within an increasing system-wide protection focus since the 2013 IASC Principals' Statement on the Centrality of Protection in Humanitarian Action:[200]

Emphasis on the protective dimension of international humanitarian action, beyond agencies with specific protection responsibilities, is relatively new and represents a step change from the more traditional focus on relief assistance.[201]

This statement, the 2015 Whole of System Review of Protection[202] and the 2016 IASC Policy on Protection form the conceptual basis of the IASC focus on protection.[203] In 2016, the Global Protection Cluster also produced a Provisional Guidance for HCT Protection Strategies.[204] A 2015 independent review of protection in the humanitarian system noted "deliberate de-prioritization of [protection] issues at the HC and HCT levels" and that the aim of the Provisional Guidance for HCT Protection Strategies is to address this and to ensure that protection is a required part of the HCT mandate.[205] In February 2017, UNFPA was successful in ensuring that GBV was specifically mentioned in the standard terms of reference for HCT.[206]

191. Ukraine government key informant. For further information, refer to the Ukraine country note.
192. Ukraine NGO key informant. For further information, refer to the Ukraine country note.
193. Multiple key informants. For more information please refer to Annex V evaluation matrix EQ4A10.
194. The Sphere Project. Sphere Handbook. 2004. https://www.spherestandards.org/handbook/editions/
195. In the revised 2018 MISP family planning has become an objective rather than an additional key priority activity. In CERF guidelines, HIV is included within life-saving criteria – https://cerf.un.org/sites/default/files/resources/FINAL_Life-Saving_Criteria_26_Jan_2010__E_0.pdf. However, there was no evidence collected within this evaluation that suggests these areas of SRHR are routinely considered life-saving by humanitarian actors, inside and outside of UNFPA. For further information, refer to Annex V evaluation matrix EQ4A10.
196. https://www.humanitarianresponse.info/en/documents/organizations/united-nations-office-coordination-humanitarian-affairs/document-type/humanitarian-needs-overview/publication-date/2018?page=1 provides a selection of such reports.
197. OCHA, UNFPA and ICRC: Concept Paper. Ending Sexual and Gender-Based Violence in Humanitarian Crises. 2019. https://az659834.vo.msecnd.net/eventsairwesteuprod/production-possibility-public/d7a20c22be0145398e4bbb9ed661f2ef
198. UNFPA regional and headquarter key informants.
199. International Rescue Committed and VOICE. Where Is the Money? How the Humanitarian System Is Failing in Its Commitments to End Violence against Women and Girls. 2019. https://www.rescue.org/sites/default/files/document/3854/whereisthemoneyfinalfinal.pdf
200. IASC. The Centrality of Protection Statement in Humanitarian Action. 2013
201. Ibid.
202. Independent Whole of System Review of Protection in the Context of Humanitarian Action. 2015
203. Global Protection Cluster Strategic Framework 2016-2019.
204. GPC Provisional Guidance Note Humanitarian Country Team Protection Strategy. 2016
205. Independent Whole of System Review of Protection in the Context of Humanitarian Action. 2015
206. https://reliefweb.int/sites/reliefweb.int/files/resources/iasc_tor_for_hcts_final_0.pdf

While the evaluation evidence is of mixed success by UNFPA in promoting GBV and SRHR as life-saving within the United Nations humanitarian space at country level, there is good evidence of UNFPA successfully promoting SRHR (under the auspices of the MISP) and GBV with governments. Examples include:

In **South Sudan**, the joint programme on GBV has improved attention of the humanitarian community to GBV. Further, UNFPA has supported the GBVIMS in South Sudan since its inception and used the data to advocate for greater attention to GBV, with successively greater investments in GBV through the pooled fund. UNFPA similarly regularly advocates for attention to SRHR, both at HCT level and with the Government, for example supporting development of a CMR protocol.[207]

Haiti demonstrates evolving perspectives on the consistency and effectiveness of UNFPA promoting SRHR and GBV as critical life-saving interventions for humanitarian response. The 2013-2016 country programme evaluation noted that UNFPA was not well identified as a rapid humanitarian response actor in the event of a disaster or crisis and not well integrated into the national response to crises. The potential of UNFPA for leading on the MISP was poorly known and therefore not integrated into contingency plans or the coordination and intervention mechanism.[208] Since 2016, however, UNFPA has become much more visible and stakeholders all report that UNFPA has promoted SRHR and GBV much more effectively.[209]

Evidence of success within government humanitarian space also includes **Turkey**, where UNFPA has worked closely with ministries to promote SRH and GBV as essential life-saving activities. There is no specific evidence of promoting SRH and GBV as life-saving at the United Nations Country Team level, but this is within a context of a government-led response with a United Nations Country Team with reduced influence.[210]

In **Indonesia**, UNFPA has led integration of the MISP into government policy and guidelines, thus ensuring it is implemented from the earliest stages of emergency response.

In the **Philippines**, the policy advice and technical and capacity building support of UNFPA to the Government resulted in an administrative order facilitating the inclusion of the MISP in all humanitarian health response planning and an inter-governmental department circular in 2017 mandating a more cohesive strategy to implement the MISP from the national level down to the communities.[211]

FINDINGS 14. UNFPA inconsistently leverages population data for informing overall humanitarian responses.

Understanding population data in humanitarian contexts is challenging. Approaches by different actors are inconsistent and often flawed, the terminology can be confusing with different datasets including total population, population in need, affected, most affected, targeted, reached and covered. There are frequently significant gaps in the data. Even when quality data exist, there is not always coordination between agencies about how such data are used.[212] The 2015 ALNAP State of the Humanitarian System Report highlighted that a "lack of solid data on people in need remains a major obstacle to understanding success or failure of a humanitarian response. Without being able to measure the proportion of people who needed aid versus who actually received it, coverage rates cannot be estimated."[213]

In 2011, the IASC Information Management Task Force developed guidelines on the Humanitarian Profile Common Operational Dataset to address many of these gaps and confusion in terminology.[214] In 2016, IASC produced additional guidance on humanitarian figures,[215] which was complemented by the HNO Guidance[216] in 2017.

Being the United Nations entity for population, UNFPA has extensive experience and expertise in population dynamics in development settings.[217] The evaluation identified some evidence that this is translating to humanitarian operations, but it is emerging and inconsistent. Until the 2019 Humanitarian Office restructuring, no humanitarian data specialist position existed in the Humanitarian and Fragile Context Branch (HFCB).[218]

In **Uganda**, UNFPA supported two assessments on internally displaced persons and presented humanitarian crisis profiles with data disaggregated by sex and vulnerability in internally displaced person and refugee hosting areas in 2016. In **Colombia**, OCHA has led an interagency initiative that includes UNFPA on information management and analysis since 2015 – Unidad de Análisis y Manejo de Información de Colombia (UMAIC) – with the goal of

207. South Sudan key informants. For further information, refer to Annex V evaluation matrix EQ4A10.
208. UNFPA. 2013-2016 Haiti Country Programme Evaluation. 2016
209. For further information, refer to the Haiti country note and Annex V evaluation matrix EQ4A10.
210. Turkey key informants. For further information, refer to Annex V evaluation matrix EQ4A10.
211. For further information, refer to Annex V evaluation matrix EQ4A10.
212. OCHA. Humanitarian Population Figures. 2016.
213. ALNAP. State of the Humanitarian System. 2015.
214. OCHA. Humanitarian Population Figures. 2011.
215. OCHA. Humanitarian Population Figures. 2016.
216. OCHA. HNO Guidance. 2017.
217. https://www.unfpa.org/resources/population-dynamics-and-policies
218. UNFPA regional key informants.

providing humanitarian, peace-building and development actors with comprehensive data.[219]

Work by UNFPA **Yemen** presents evidence of a good understanding of population dynamics: the 2016 population data factsheet includes pregnant women, live births per year, predicted pregnancies to end in miscarriage/unsafe abortion, women of reproductive age, at risk of sexual violence, as well as basic indicators such as maternal mortality ratio, adolescent birth rate, contraceptive prevalence rate, education rates, etc. UNFPA provides population data to the whole humanitarian community within Yemen, including government actors and supports population dynamics/statistics government officers for this function to remain operational during the crisis. UNFPA also leads the rapid response mechanism, which delivers on the basis of both UNFPA population data and the International Organization for Migration (IOM) displacement tracking mechanism data and then also verifies population statistics while delivering first phase response, to provide this data back to clusters for further assistance. In 2019, UNFPA and UNICEF will update the maternal mortality ratio indicator (last updated in 2013).[220]

However, these country-level examples are country-specific and country-led and not representative of a global institutional strategy by UNFPA to leverage population dynamics expertise within humanitarian response, nor how to best do this in a way that adds most value (given that OCHA leads on humanitarian population data). Respondents have reported that this represents a missed opportunity for UNFPA.[221]

FINDINGS 15. UNFPA data systems are not adequate for monitoring outcome-level humanitarian results. Results data has many different uses, including programming, communications and resource mobilization. While this evaluation has identified evidence of the first two, the use of UNFPA results data for resource mobilization has limited evidence.

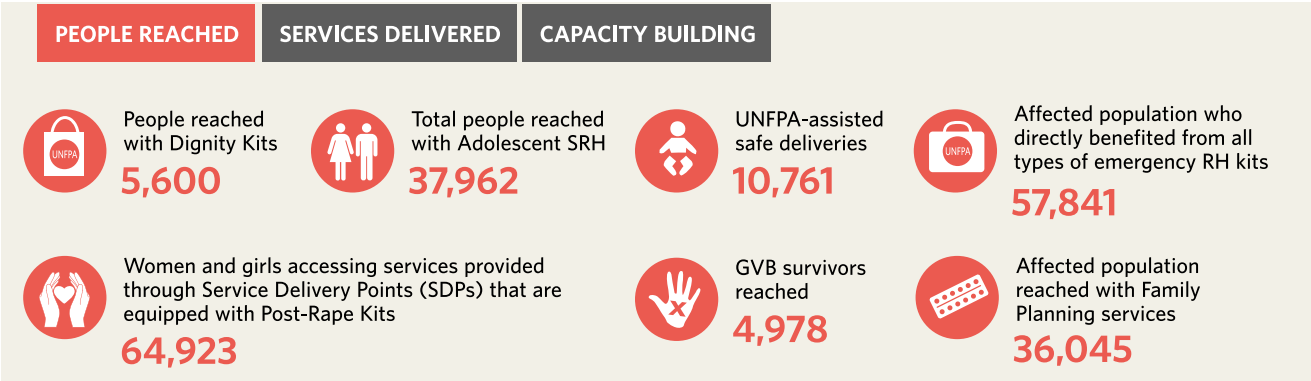
An important example of efforts to improve data for communications is the implementation of the UNFPA online transparency portal (see below), whereby activity-level results data are consolidated at a country level for a broad audience. However, these consolidated activity numbers have limited meaning when taken out of country context and with no denominator (overall need and target figures) to provide context. For some country datasets, updated HNO figures are provided, which do give context, but this is not consistent across all country data sets.

For programming purposes, the data presented in Figure 7 has limited use. There is no evidence that UNFPA currently collects outcome-level results data across common indicators in a way that can be used consistently across humanitarian response to monitor programme effectiveness.

The GBVIMS is successfully used across many countries by UNFPA and GBV sub-clusters to understand GBV trends and to adapt programming and monitor coverage while maintaining confidentiality of survivors and service providers.

In **Turkey**, the Whole of Syria cross-border response has a useful and effective dashboard to provide information about services, coverage and other activities that can be filtered per interagency hub (Jordan, Damascus and Gaziantep).

FIGURE 4: *Example transparency portal (DRC)*[222]



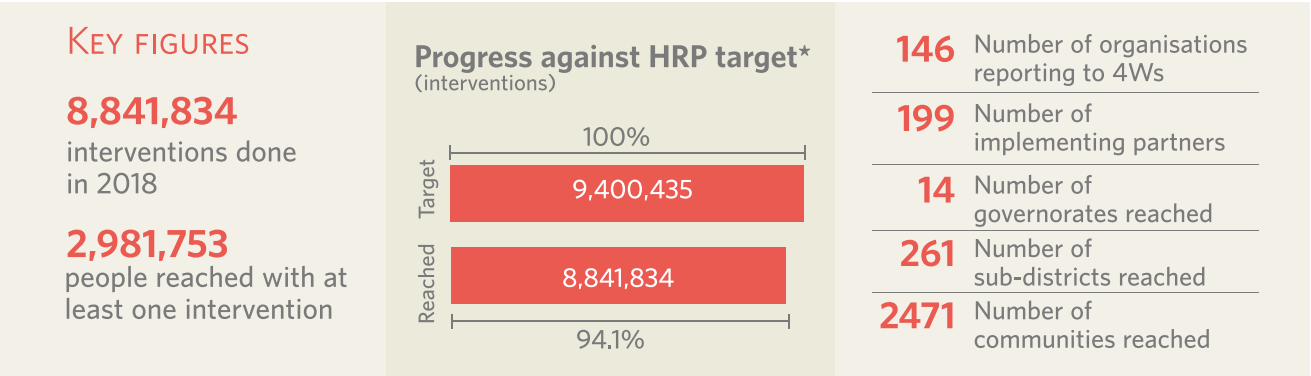
219. UNFPA. 2018 Annual Planning – Colombia. 03 July 2018.

220. Yemen key informants. For further information, refer to Annex V evaluation matrix EQ4A11.

221. Multiple key informants.

222. https://www.unfpa.org/data/emergencies/democratic-republic-congo-humanitarian-emergency

FIGURE 5: *Whole of Syria GBV dashboard 2018*[223]



In **Chad**, the evaluation of the Sixth Country Programme (2012-2016) concluded that the pilot experience of the GBVIMS in Goz-Béida was well received: the six-day GBVIMS training in 2016 was led by the GBVIMS Mali Desk Officer and was attended by 40 individuals from 23 organizations.[224] UNFPA report that GBVIMS data is now routinely utilized and shared more broadly within the humanitarian community for planning and programming purposes.[225]

In **Ukraine**, UNFPA introduced the GBVIMS in 2015 (at the beginning of the conflict response) to ensure that GBV data was collected, collated, managed and utilized within global GBV data standards. In 2018, a GBV hotline also joined the GBVIMS and, as of 2019, there was a comprehensive GBV data management system, including monthly reporting.[226,227]

In **DRC**, UNFPA was an early adopter of the GBVIMS. A 2014 global evaluation of GBVIMS implementation noted the high value of government ownership of an information management system on GBV.[228]

FINDINGS 16. There are many examples of UNFPA increasing resilience through working with service providers at the facility level or with government at the national level but limited evidence of UNFPA programming changing resilience at individual or community level. Building resilience occurs on individual, household, community, institutional and national levels. UNFPA has had most success building resilience at national level with some additional success at community level.

In **Indonesia**, the UNFPA overall approach to disaster preparedness aims to support the resilience of the Government and key civil society actors to respond to emergencies. UNFPA has worked with relevant ministries to improve data capacity for emergency preparedness, with preparatory research, assessments and planning dating back to crises from 2007 and even building on lessons learned from the Asian Tsunami of 2004. UNFPA contributed significantly to the development of provincial infographics (published in 2014) covering the seven main sectors of population, food security, livelihood, education, health, water and sanitation and disaster management. Informants report that UNFPA training related to DRR has supported improved government awareness on disaster response for the MISP and WFS in key disaster-prone regions in Indonesia. As of January 2019, the Government endorsed inclusion of the MISP in all disaster response, including regular renewal of MISP trainings in disaster-prone areas.[229]

In **Haiti**, stakeholders endorsed UNFPA investments in MISP training that builds resilience at service provider level within communities. Inclusion of the MISP within the midwifery curriculum is a further achievement, with all evaluation respondents who had received the training reporting it as useful and welcome, particularly the GBV component.[230] However, beyond MISP training conducted by UNFPA, respondents reported limited focus on increasing preparedness either specifically within the health sector or more broadly. Stakeholders agreed with the sentiment that overall, preparedness "isn't great – and is nothing near where

223. https://www.humanitarianresponse.info/en/operations/whole-of-syria/whole-syria-protection-sector-dashboard.
224. GBV sub-cluster. Rapport narratif annuel des activités de prise en charge des victimes de VGB. 2016.
225. Chad UNFPA key informants. For further information, refer to Annex V evaluation matrix EQ4A11.
226. Ukraine key informants and UNFPA. RFQ: UNFPA/UKR/RFQ/18/12 Evaluation of UNFPA psychosocial support to survivors of gender-based violence in Ukraine through PSS mobile team model. October 2018. For further information, refer to the Ukraine country note.
227. There is no evidence of government, NGOs, or other United Nations agencies routinely using GBVIMS data to inform programming.
228. Evaluation of the Gender Based Violence Information Management System (GBVIMS) Prepared by: International Solutions Group for UNFPA. September 2014.
229. Indonesia key informants. For more information please refer to the Indonesia country note and Annex V evaluation matrix EQ4A12.
230. Haiti key informants. For more information please refer to the Haiti country note and Annex V evaluation matrix EQ4A12.

it should be."[231] This concern is especially important, given the prevalence (and increasing risk) of climate-related disasters in Haiti.

In **Yemen**, UNFPA supported continuous small-scale interventions on the MISP and CMR to ensure sustained level of service provider expertise through existing state structures. UNFPA has also supported the Ministry of Health for the reproductive, maternal and newborn health (RMNH) strategy through to 2021.

In the **Philippines**, UNFPA humanitarian programming has contributed to increased resilience by building capacities in terms of disaster preparedness via the MISP. For example, the Government of the Philippines is now investing its own funds for the purchase of dignity kits and RH kits. Further, due to the cyclical nature of disasters in the country, many local government representatives have now received UNFPA training on gender and/or GBV. UNFPA has supported attention to SRH and GBV in disaster management frameworks, with significant progress at the national level. Even so, many local government units have reportedly not yet integrated SRH and GBV needs within their local DRR plans.[232]

There are some examples of building resilience at community levels. The **Turkey** cross-border response provides evidence of a country-level focus on capacity building through both the GBV sub-cluster and the RH working group, which seek to build the capacity and resilience of grassroots organizations and service providers working inside **Syria** in preparation for a transition to longer-term recovery and rehabilitation. Since 2016, UNFPA has undertaken a significant midwifery capacity building programme. According to the health cluster, UNFPA has done an "excellent job" with this initiative.[233]

There are limited examples of building resilience at individual level. In **Bangladesh**, the women-led community centre (WLCC) programme is currently providing training and activities for the first cohort of women (who attend classes and sessions for six months). Even before the WLCC programme was established, respondents reported seeing a change in the behaviour of Rohingya refugees, becoming more aware of their rights and willing to ask for services that they need – including the WLCC programme which was developed based on requests from women and girls. Similar activities take place in **Indonesia** and **Colombia**. However, such efforts are typically not strategically included in response efforts, in many cases contrary to the expressed needs of affected populations.

231. Haiti other United Nations agency key informant. For more information please refer to the Haiti country note.

232. For further information, refer to Annex V evaluation matrix EQ4A12.

233. Turkey key informants. For further information, refer to Annex V evaluation matrix EQ4A12.

EVALUATION QUESTION 5:
COVERAGE

To what extent is UNFPA achieving its objectives in terms of humanitarian action? To what extent does UNFPA humanitarian programming achieve both geographic and demographic coverage?

FINDINGS

17. The humanitarian presence of UNFPA has increased significantly over the period of this evaluation. However, UNFPA is still considered a relatively small humanitarian actor by the international humanitarian community.

18. There is clear evidence of geographical targeting based on highest need, limited only by challenges of resources and/or security and access. However, there is no systematic approach across the countries included within this evaluation for geographical targeting.

19. In terms of demographic coverage, UNFPA has an increasing focus on programming for adolescent girls, often within a wider adolescent/youth humanitarian programme area as articulated in strategic documents such as the UNFPA Strategic Plan 2018-2021. There is limited implementation of inclusion of persons with disabilities, although most UNFPA country offices included in this evaluation report increasing inclusion of this vulnerable group. There is extremely limited programming for LGBT+ populations.

FINDINGS 17. The humanitarian presence of UNFPA has increased significantly over the period of this evaluation. However, UNFPA is still considered a relatively small humanitarian actor by the international humanitarian community. As an organization, UNFPA is globally perceived by all stakeholders to have fewer humanitarian staff than other humanitarian response agencies.[234,235] UNFPA respondents report an internal culture of being an agency that can do more with less but the value of this approach is increasingly being questioned both internally and externally.[236]

While direct comparisons between the absolute number of staff within UNFPA with other agencies of differing sizes are overly simplistic,[237] the broad consensus from respondents both within UNFPA and across other stakeholders is that UNFPA does not currently have enough humanitarian staff (at all levels, global, regional, or country) to fulfil its programming and coordination obligations.[238]

The key message highlights the fact that UNFPA staff in highly vulnerable contexts are frequently thinly stretched. This impacts on their well-being and performance as well as on the reputation of UNFPA as a humanitarian actor.[239]

In ESARO (UNFPA East and Southern Africa Regional Office) you can count on one hand the staff who know humanitarian response across the whole region.[240]

The surge mechanism has expanded since its creation, particularly between 2016 and 2019, with the introduction of an external roster and standby partnership agreements. It is important to note that the surge is itself symptomatic of limited permanent humanitarian expertise within UNFPA. An over-reliance on surge was noted as part of a presentation made to the UNFPA Oversight Advisory Committee in April 2019 on the surge mechanism, with another significant challenge noted being the inability of UNFPA to meet IASC system-wide response standards of ensuring sufficient humanitarian staff on the ground within 72 hours of the declaration of an L3 emergency (within 21 days for non-L3 emergencies).[241] In 2018, only 24 per cent of surge deployments were on the ground within 21 days.[242]

234. Multiple key informants. For further information, refer to Annex V evaluation matrix EQ5A13 and EQ6A16.

235. There is no clear global consolidated data available within UNFPA on the number of humanitarian personnel within the organization.

236. Multiple UNFPA key informants. For further information, refer to the thematic paper on human resources for humanitarian action and Annex V evaluation matrix EQ5A13 and EQ6A16.

237. For example, UNICEF is appealing for US$3.9 billion for humanitarian action in 2019 compared to the UNFPA appeal for US$530 million. UNFPA. Humanitarian Action Overview. 2019. https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_HumanitAction_2019_PDF_Online_Version_16_Jan_2019.pdf

238. Multiple key informants. For further information, refer to Annex V evaluation matrix EQ5A13 and EQ6A16.

239. UNFPA. Meta-Analysis of Engagement of UNFPA in Vulnerable Contexts. 2018.

240. UNFPA key informant.

241. The categorization of L1, L2 and L3 has recently been replaced by scale-up protocols. However, as L1, L2 and L3 categorization terminology applies to the period of this evaluation, 2012-2018, this is referenced in this report. For further information, refer to https://interagencystandingcommittee.org/iasc-transformative-agenda/content/iasc-humanitarian-system-wide-scale-protocols-released

242. UNFPA. Oversight Advisory Committee Meeting Presentation 10-12 April 2019: Surge Mechanism.

This impacts negatively on the reputation and credibility of UNFPA at country level and is exacerbated by the limited humanitarian human resources at country level, which constitutes the underlying issue of coverage.

Human resources – this is a burning issue and UNFPA is lagging behind in terms of staffing. We used to have roving staff and they were used for some time where people can be deployed for 3-6 months and not really effective. And people deployed and sometimes for 3 weeks...come and go.[243]

I don't think we have enough support for staffing. Maybe in our settlements we have some with team leaders only (1 or 2 officers) and you get volunteer support staff on the ground. But in terms of staffing, this is not enough for us and we have a lot of data to be entered and cannot do so.[244]

Three factors challenge the surge mechanism's capacity to meet humanitarian human resource needs:

- The changing quantity and quality of humanitarian crises, with more protracted and complex situations and increased numbers of people in acute humanitarian need year on year
- The more formalized responsibilities of UNFPA in humanitarian action
- The increased profile of SRHR, GBV and youth within humanitarian response.

Globally, UNFPA significantly increased its humanitarian function in 2019 by upgrading the HFCB to a Humanitarian Office. This elevates humanitarian programming within UNFPA to be more on an organizational par with development programming. The new Humanitarian Office has nine new posts, bringing the total number of positions within the new Humanitarian Office to thirty three.[245]

At regional level, UNFPA is less consistent,[246] with the Latin America and Caribbean Regional Office (LACRO) having (in mid-2018) fewest management resources (no core-resourced humanitarian position)[247] and the Asia-Pacific Regional Office (APRO) having most, with multiple humanitarian positions, primarily funded via other resources. All other regions have one humanitarian coordinator or advisor.[248]

For this whole region, there is only one acting humanitarian specialist offering 23 countries support. Can you imagine one person looking at 23 countries? And that one is not even permanent, it is acting.[249]

The evaluation evidence supports the conclusion that a single dedicated humanitarian position per regional office is inevitably a reactive role focused on responding to events within humanitarian crises as they occur, rather than having time to develop and roll out regional/sub-regional strategies, plan for training, share learning, attend regional coordination meetings and proactively support growth of UNFPA as a humanitarian response agency. The evaluation noted some capacity of regional advisors to roll out the minimum preparedness action plans (MPAs) and devote time to developing regional strategies and providing country-level support. For example, the Arab States Regional Office (ASRO) has a regional resilience framework, developed in 2016 and the West and Central Africa Regional Office (WCARO) has a 2016 regional strategy based around five pillars of MISP, GBV, data, preparedness and resilience. The Eastern Europe and Central Asia Regional Office (EECARO) has systematized templates facilitating implementation and monitoring of the MPAs.[250]

These initiatives are laudable, but the development, implementation, monitoring and understanding of impact of these initiatives is impeded by the limited humanitarian human resources at regional level. The 2018 UNFPA Evaluation Office's Meta-Analysis of the Engagement of UNFPA in Highly Vulnerable Contexts noted that:

[The] levels of staff in regional offices for emergency preparedness and response are not commensurate with providing expected support for country offices, engaging in regional coordination and networking and managing level 2 emergency responses.[251]

Further, when a crisis occurs in regions consisting of mainly middle-income countries that attract fewer external humanitarian resources – for example, the L3 Venezuela crisis in Latin America – UNFPA and its existing partners have limited humanitarian experience and expertise. This is particularly the case for direct service delivery (for UNFPA, given these countries are generally pink quadrant countries – those deemed to have the smallest needs and the

243. Nigeria UNFPA key informant.

244. Uganda UNFPA key informant.

245. However, the humanitarian office report that a number of these posts are not funded with regular resources and remain vacant.

246. Multiple UNFPA key informants. For further information, see the thematic paper on human resources for humanitarian action and evaluation matrix EQ5A13 and EQ6A15.

247. The current regional programme adviser is also the double-hatting regional humanitarian adviser and is currently, due to the escalating Venezuela crisis, indefinitely acting as regional humanitarian adviser full-time, with no cover for the programme adviser function.

248. APRO has just, in June 2019, appointed a third full-time humanitarian staff position.

249. UNFPA key informant.

250. UNFPA regional key informants.

251. UNFPA. Meta-Analysis of Engagement of UNFPA in Vulnerable Contexts. 2018.

resources to address them),[252] further hampering a rapid scale-up commensurate with needs.[253]

At country level, the evaluation identified no specific corporate requirements for key, core, permanent humanitarian positions. Thus, humanitarian capacity varies widely across country contexts and is heavily dependent on external programme resources, which is sub-optimal for effective coverage:[254] "humanitarian work is labour-intensive and the more people you have close to the ground is critical."[255]

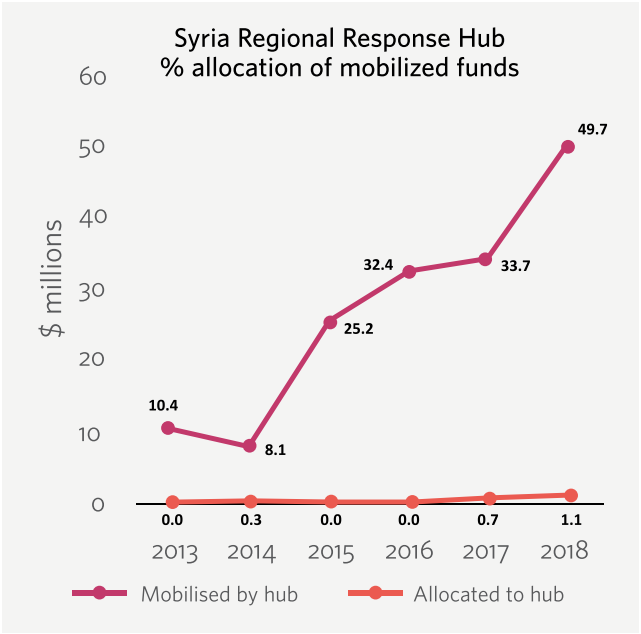
The evaluation could not identify any consistent approach to humanitarian response staffing within UNFPA country offices. This finding, based on absence of evidence of a consistent approach, was supported by the testimony of key informants to the evaluation: "We have to define what staffing for humanitarian response is required, what is the minimum. What I am seeing right now, it just depends on Country Representatives and this causes gaps."[256]

Therefore, while the planned increase in resources at global level is acknowledged (although it is recognized that many of the new positions will be funded from as-yet unsecured other resources), respondents within UNFPA question the geographical targeting of this investment:[257] "We need to think how to strengthen capacity at country level. There is a lot of emphasis put on strengthening headquarters capacity and we need to balance that."[258]

The UNFPA Strategic Plan 2018-2021 outlines a process of allocating resourcing to countries based on pre-defined indicators which include the humanitarian/risk factor, based on INFORM data.[259,260] However, there is clear consensus across all internal and external respondents that UNFPA systematically relies too much on surge rather than securing funding for both surge and roving team responses and for necessary longer-term positions.[261]

There are clear examples where initial UNFPA investment in full-time humanitarian positions led to securing additional funding for the positions themselves, additional positions and expanded humanitarian programming. For example, the Syria regional response hub[262], which was established initially in 2012 with a regional humanitarian coordinator position funded by ASRO, went on to secure millions of dollars for the UNFPA Syria regional response.

FIGURE 6: *Syria regional response hub mobilized funds*[263]



The hub has retained 3 per cent or less of annual resources mobilized as running costs. The multi-year nature of funding has allowed retention of some senior staff for over two years. This has benefitted the response and limited the reliance on a succession of surge and short-term contract staff, a dynamic inimical to retention of institutional memory and maintenance of relationships with national actors. While a regional hub will not add value to all responses (and few responses attract such attention as Syria) this example strongly indicates that resourcing appropriately contracted humanitarian staff is a demonstrably good return on investment.

Individual country analyses present many examples of how UNFPA humanitarian response coverage is incommensurate with needs. In **Haiti**, UNFPA has a highly concentrated capital city staffing footprint with no current permanent staff or offices located in provinces (departments). UNF-

252. See UNFPA Strategic Plan 2018-2021, Annex 4. Business model. 2018.
253. Multiple key informants. For further information, refer to Annex V evaluation matrix EQ5A13 and EQ6A15.
254. Multiple key informants. For further information, refer to Annex V evaluation matrix EQ5A13 and EQ6A15.
255. Multiple key informant. For further information, refer to Annex V evaluation matrix EQ5A13 and EQ6A15.
256. UNFPA key informant.
257. Multiple UNFPA key informants. For further information, refer to Annex V evaluation matrix EQ5A13 and EQ6A15.
258. UNFPA key informant.
259. UNFPA. Meta-Analysis of Engagement of UNFPA in Vulnerable Contexts. 2018.
260. INFORM is a global, open-source risk assessment for humanitarian crises and disasters. It can support decisions about prevention, preparedness and response. http://www.inform-index.org
261. Multiple key informants. For further information, refer to Annex V evaluation matrix EQ5A13 and EQ6A15.
262. Note that Whole of Syria was not included within this humanitarian evaluation, but this information has been extracted from the 2018 Syria regional response evaluation. https://www.unfpa.org/admin-resource/evaluation-unfpa-response-syria-crisis-2011-2018
263. Ibid.

PA reported maintaining its field presence through regular (but ad hoc and unsystematic) monitoring visits, but this has obvious limitations compared to a permanent presence, particularly when compared to other United Nations agencies that maintain a permanent sub-national presence (such as UNICEF).[264]

As with supplies, pre-positioning of personnel – i.e., a permanent presence in high-risk districts – contributes to speed and quality of response. This must be balanced against working via and providing mentoring and support to, government and civil society partners that typically have more presence. Respondents in **South Sudan** reported that UNFPA staff need more physical presence in the field[265] and respondents in **Somalia** noted that the office continues to face difficulty in reaching remote and nomadic populations as well as internally displaced persons within the zones where UNFPA is present.[266]

However, there are also examples of contexts of robust UNFPA coverage where its humanitarian response is viewed as on par with other United Nations response agencies. In **Yemen**, UNFPA has achieved nearly universal geographic coverage via five humanitarian hubs and adheres to the severity/vulnerability scales as outlined for the whole humanitarian community within the HRP.[267] In **Nigeria**, UNFPA works in all 36 states as well as the Federal State Territory via four sub-offices. A partnership with the Nigerian Red Cross (as well as other agencies) allows for (albeit intermittent) access to hard-to-reach areas of need.

FINDINGS 18. There is clear evidence of geographical targeting based on highest need, limited only by challenges of resources and/or security and access. However, there is no systematic approach across the countries included within this evaluation for geographical targeting. The evaluation did not identify any evidence of corporate guidance for geographical targeting specifically for SRHR and GBV responses available to country programmes. Evidence from stakeholders indicates an appetite for institutional guidance which should embody UNFPA policy for targeting of the most vulnerable specific to SRHR and GBV needs and takes into account access and security issues, funding availability, partner availability and duty of care to staff. Many UNFPA country offices follow an inter-agency vulnerability ranking where available, but this does not negate the requirement for a consistent UNFPA approach. Examples (both strong and weak) of different approaches to geographical coverage by UNFPA include:

In **Turkey**, the refugee response has sought to ensure that WGSS have been located in areas most densely populated by refugees.[268] For the cross-border response, UNFPA has functioning mapping systems through the protection cluster and the health cluster. While there are recognized geographical gaps inside Syria, this is not due to lack of attention or coordination but rather challenges of access to insecure areas.

In **Uganda**, UNFPA, sister United Nations agencies and implementing partners map priority areas for intervention bi-annually. Cost per beneficiary, presence of other actors and activity history is considered before strategic intervention, to demonstrably target and impact national/district indicators.[269]

In **South Sudan**, UNFPA signed a memorandum of understanding with UNHCR in 2012 to utilize UNHCR's field infrastructure and partners to reach affected populations, reaching more beneficiaries in the field. While UNFPA field staff is currently limited to five hubs, they provide supplies to all humanitarian actors across the country and support delivery of RH and GBV services in nearly all the states of South Sudan.[270]

In **Ukraine**, however, there is no UNFPA presence in the non-government-controlled areas (NGCAs[271]) and limited presence close to the contact line where the most vulnerable populations are located. Analysis by OCHA and other humanitarian partners has increasingly determined that those living in the NGCAs and those living along the contact line are the most vulnerable and most-in-need.[272] Since 2016, CERF funds have been earmarked exclusively for NGCAs and contact line projects,[273] yet UNFPA works in GCAs only.[274]

FINDINGS 19. In terms of demographic coverage, UNFPA has an increasing focus on programming for adolescent girls, often within a wider adolescent/youth humanitarian programme area as articulated in strategic documents such as the UNFPA Strategic Plan 2018-2021. There is limited implementation of inclusion of persons with disabilities, although most UNFPA country offices included in this evaluation report increasing inclusion of this vulnerable group. There is extremely limited pro-

264. Haiti key informants. For further information, refer to the Haiti country note and Annex V evaluation matrix EQ5A13.
265. South Sudan key informants. For further information, refer to Annex V evaluation matrix EQ5A13.
266. Somalia key informants. For further information, refer to Annex V evaluation matrix EQ5A13.
267. For further information, refer to Annex V evaluation matrix EQ5A13.
268. Turkey key informants. For further information, refer to Annex V evaluation matrix EQ5A13.
269. Ibid.
270. For further information, refer to Annex V evaluation matrix EQ5A13.
271. Humanitarian response actors in Ukraine have adopted the terms 'government-controlled areas' and 'non-government-controlled areas' to reflect the geographical divisions of the humanitarian response, as noted in successive Humanitarian Needs Overviews 2015-2019.
272. OCHA. Humanitarian Needs Overview. 2018.
273. OCHA. HRP Prioritization Criteria, Final Version November 2016. 2016
274. For further information, refer to the Ukraine country note and Annex V evaluation matrix EQ5A13.

gramming for LGBT+ populations. In relation to youth and adolescents, UNFPA has an increased focus on adolescents and youth,[275] with a sub-focus on adolescent girls. For example, in Haiti, UNFPA works with NGO partners to reach populations of adolescent girls using the Women's Refugee Commission/Population Council girl roster methodology to segment and prioritize the youngest and otherwise most vulnerable.[276]

In **Indonesia**, UNFPA has supported work to raise the profile of youth needs and rights in emergencies, although not with adolescent girls specifically. UNFPA has invested in the needs of youth in emergencies in Central Sulawesi province via assessments, youth-friendly spaces and advocacy with government to have youth needs more formally recognized and addressed during and after emergency response.[277]

With respect to persons with disabilities, there is limited evidence of existing programming that is proactively designed for the inclusion of persons with disabilities, although neither was there any evidence to indicate deliberate exclusion. Indeed, across all contexts, where queried, UNFPA country informants reported intentions to further consider this population – although, again, with few examples. UNFPA and partner informants in different countries highlighted the challenges of inclusion of persons with disabilities, across issues of funding, inappropriate infrastructure and lack of technical expertise.[278]

Respondents in **Bangladesh** noted challenges on how to categorize individuals with non-obvious disabilities and how to adjust programming to ensure inclusion.[279] A UNFPA respondent reported it as "a weak area, not just for humanitarian but also for development programming."[280] In DRC, respondents noted that the mobile clinic model increases accessibility to women with disabilities. UNFPA reported efforts to identify and address the needs of persons with disabilities in its programmes, notably seeking feedback on GBV issues from small loosely organized groups of persons with disabilities.[281]

Evidence from stakeholders in **South Sudan** attests to conversations about how to best include women and girls with disabilities into UNFPA programming and the country office has appointed a focal point on disability and mandated inclusion of attention to persons with disabilities in partner agreements.[282]

In 2018, UNFPA launched guidelines on working with women and young persons with disabilities[283] that purport to cover both development and humanitarian settings. However, they lack substantive consideration of (a) differentiated challenges between women with disabilities and young people with disabilities, (b) exacerbated challenges and new challenges in humanitarian contexts for persons with disabilities and (c) challenges faced by humanitarian actors attempting to ensure inclusion during crises. This single set of guidelines, primarily for development settings, but claiming to cover humanitarian contexts equally and adequately, insufficiently accounts for the specific and additional challenges for persons with disabilities in humanitarian settings nor presents mitigation measures for such challenges.[284]

Regionally, APRO has demonstrated policy progress on inclusion of persons with disabilities in humanitarian action via its participation in the development of the IASC guidelines on the inclusion of persons with disabilities in humanitarian action (finalized May 2019).[285] In November 2018, APRO hosted a strategic dialogue on SRHR and GBV in humanitarian settings, which also looked specifically at making humanitarian preparedness and response more inclusive of persons with disabilities.[286] APRO reported on work in mid-2019 to adapt the content of dignity kits and distribution strategies for women and girls with disabilities in emergencies. This entails Pacific-wide consultations with disability organizations and the Pacific Disability Forum, as well as with local organizations that work with GBViE response.[287]

Evidence of humanitarian programming with or for LGBT+ populations is very limited. In May 2019, the UNFPA Executive Director reaffirmed the UNFPA commitment to working with and for LGBT+ populations:

275. Note that adolescence is defined as 10-19. Youth is defined as 15-24. 'Young people' refers to adolescents and youth, including those 10-24.
276. Haiti key informants. For further information, refer to the Haiti country note and Annex V evaluation matrix EQ5A14.
277. Indonesia key informants. For further information, refer to the Indonesia country note and Annex V evaluation matrix EQ5A14.
278. Multiple key informants. For further information, refer to Annex V evaluation matrix EQ5A14.
279. Bangladesh key informants. For further information, refer to Annex V evaluation matrix EQ5A14.
280. Ibid.
281. Multiple key informants. For further information, refer to Annex V evaluation matrix EQ5A14.
282. For further information, refer to Annex V evaluation matrix EQ5A14.
283. UNFPA. Women and Young Persons with Disabilities: Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights. 2018. https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-WEI_Guidelines_Disability_GBV_SRHR_FINAL_19-11-18_0.pdf
284. Refer to the guidelines: UNFPA. Women and Young Persons with Disabilities: Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights. 2018.
285. Age and Disability Consortium. Humanitarian Inclusion Standards for Older People and People with Disabilities. 2019.
286. UNFPA. Report on the Strategic Dialogue on Sexual and Reproductive Health and Gender-Based Violence in Emergencies. 2018.
287. UNFPA key informants.

"UNFPA, the United Nations sexual and reproductive health agency, is committed to addressing the specific needs of LGBT+ people. Around the world, we support health, comprehensive sexuality education and advocacy initiatives that help marginalized communities and lift up young people, including the LGBT+ youth often left behind..."[288]

However, this commitment is not seen in practice in humanitarian settings. Across the 15 countries examined for this evaluation only one – **Turkey** – had specific humanitarian programming for LGBT+ populations. The key refugee groups project, which started in 2018, seeks to mitigate restricted access of vulnerable groups to services. The project assists Syrian, Persian, Iraqi and other refugees.

No other examples of work for LGBT+ populations were identified, despite widespread legal, political, social/cultural and economic discrimination against LGBT+ individuals.[289] UNFPA respondents in many countries spoke to an unspecified aspiration to work with LGBT+ populations while citing challenging legal and socio-cultural issues that require an expertise that UNFPA has not yet developed.[290]

288. Statement by UNFPA Executive Director Dr. Natalia Kanem for the International Day Against Homophobia, Biphobia and Transphobia 17 May 2019. https://www.unfpa.org/press/statement-unfpa-executive-director-dr-natalia-kanem-international-day-against-homophobia

289. Of the fifteen countries covered by this evaluation, same-sex relations are legal in seven: DRC, Haiti, Indonesia, Ukraine, Colombia, Philippines and Turkey, but legal and social discrimination against LBGQTI individuals is present to a greater or lesser extent even within these countries.

290. Multiple key informants. For further information, refer to Annex V evaluation matrix EQ5A14.

EVALUATION QUESTION 6:
EFFICIENCY

To what extent do UNFPA inputs (financial and human resources) and internal systems, processes, policies and procedures support an enhanced humanitarian response?

FINDINGS

20. Over the period 2012-2019, UNFPA successfully increased access to other resources, particularly centralized pooled funding – such as country-based pooled funds and the CERF.

21. Despite positive progress in the past decade, UNFPA still struggles to get the right people in the right place for humanitarian response on the right contractual modality.

22. Fast-track procedures (FTPs) are generally viewed by UNFPA staff as useful for humanitarian response where they are activated.

23. The low level of financial risk acceptance by UNFPA undermines its overall performance as a humanitarian actor.

24. At country level, strong partnerships with government, sister agencies, NGOs and CSOs are a cornerstone of UNFPA development programming. Robust government partnerships can be a considerable advantage in humanitarian response. However, UNFPA has no standardized method of leveraging these partnerships across all humanitarian action areas, nor with other partners such as academic institutions or the private sector.

FINDINGS 20. Over the period 2012-2019, UNFPA successfully increased access to other resources, particularly centralized pooled funding – such as country-based pooled funds and CERF. Humanitarian needs have increased significantly since 2012, when the annual OCHA overview for that year indicated overall humanitarian funding requirements of US$12.7 billion to 54 million people in need.[291] Global requirements for 2019 have been calculated at US$21.9 billion to reach 93.6 million people out of a total of 131.7 million people in need,[292] a more than doubling of requirements in eight years.

UNFPA humanitarian capacity and resources have also increased, with UNFPA reporting receipt of US$172,625,466 in humanitarian funding in 2018,[293] accounting for 16 per cent of total 2018 spend.[294] As noted previously, in 2015 (the earliest year for which data is publicly available), UNFPA humanitarian spend was US$82,386,133,[295] less than half the 2018 humanitarian funding total. An increasing share originates from inter-agency funding mechanisms such as CERF, from which UNFPA is increasing its allocation (albeit not consistently – there was a decrease from 2016 (5.3 per cent) to 2017 (5 per cent) and 2018 (4 per cent)).[296]

291. OCHA. 2012 Annual Report. 2012.

292. OCHA. Global Humanitarian Overview, 2019. 2019.

293. https://www.unfpa.org/data/dashboard/emergencies

294. UNFPA total expenses for 2018 is reported as $1,086,020,000. https://www.unfpa.org/sites/default/files/resource-pdf/A_74_5_Add.8_E.pdf

295. UNFPA. Humanitarian Action 2016 Overview. 2016.

296. Note that between 2016 and 2017, the overall CERF funding decreased.

TABLE 4: *CERF funding by year*

Year	Amount allocated to UNFPA	UNFPA allocation as a % of total CERF funds
2010	$10,456,853	2.5%
2011	$10,723,332	2.5%
2012	$11,494,843	2.3%
2013	$14,406,523	3%
2014	$15,179,496	3.3%
2015	$16,086,989	3.4%
2016	$23,148,417	5.3%
2017	$21,032,967	5%
2018	$20,063,913	4%
2019 (September 2019)	$34,782,057	7.1%

Source: https://cerf.un.org/what-we-do/allocation-by-agency

In **Yemen**, UNFPA recorded the highest funded years in 2016 and 2018 – with good geographical coverage, operating in all five of the United Nations inter-agency hubs; good staffing, with dedicated national GBV and RH humanitarian coordinators, separate from GBV and RH programme staff; and, as the lead agency for the inter-agency rapid response mechanism. UNFPA Yemen reports meeting most needs with current financial resources, although some of the most consistent donors to the Yemen crisis are regional with no principled attachment to UNFPA-mandated areas, hence not typical UNFPA global donors.

In **Indonesia**, UNFPA is perceived by peer stakeholders as efficient, with the ability to produce good results with limited funds. To manage funding limitations, the country office allocated 10-15 per cent of budget for different thematic outputs to support humanitarian response. However, this was inadequate to meet needs in 2018, thus the country office reallocated development funding to humanitarian programming.[297]

In **Nigeria**, UNFPA mobilized US$20 million in 2018 from non-core resources. UNFPA has also accessed CERF funding at least once per year since 2013 – crucial to sustaining services and activities or for urgent mobilization to be undertaken, even if the resources received were often less than those requested.

Despite the above evidence of funding mobilization at country level, there is little evidence of UNFPA complementing this with global funding mechanisms which allow adequate seed funding or bridge funding for rapid country humanitarian responses and for programming to continue without interruptions or delays. When a crisis occurs, UNFPA country offices can apply for UNFPA emergency funding mechanisms, which currently include an emergency fund and a humanitarian response reserve.[298] The humanitarian response reserve received an initial allocation of $7.5 million on establishment in 2015 but, due to a reported lack of utilization, this level was reduced to $5 million.[299] The emergency fund (EF) was created at the same time by the Executive Board to access resources specifically for humanitarian and preparedness-related interventions, initially with an annual allocation of $1 million, which has since increased to $10 million.[300] These two mechanisms are to be replaced by a humanitarian trust fund (being established at the time of research) with no ceiling limit but with reported limited donor interest.[301]

UNFPA also implements two revolving funds for commodities: the Global Contraceptive Commodity Programme (GCCP) fund, which is US$5 million and which is used to procure RH kits and managed by the Procurement Services

297. UNFPA. Summary Report Central Sulawesi. 2018

298. DFID. Review of UNFPA Supplies in Humanitarian Settings, May-August 2018. 2018

299. UNFPA headquarter key informants.

300. Ibid.

301. Ibid.

Branch (PSB),[302] and the supplies sexual and reproductive health fund, which is US$14 million and is used for RH kits and other (non-humanitarian) inventory. In recent years, the GCCP fund has been more fully utilized, to the point that now the fund is fully tied up in stock (which, at a US$5 million limit, is insufficient for global requirements for RH kits; in 2018 this fund was turned over twice).[303,304] The supplies SRH revolving fund is officially used for "allocating money tied up in work-in-progress and purchase orders."[305] Initially clear differentiation between the two funds has disappeared over the years, with both now being used for inventory purchases because the GCCP is insufficient to meet RH kit needs.[306] Two clear challenges emerge from the analysis of these mechanisms:

- While seed funding (from the emergency fund or humanitarian response reserve/humanitarian trust fund) at the onset of a crisis is useful, it is small – even when fully funded at US$10 million, this still represents only 6 per cent of the total UNFPA humanitarian expenditure in 2018 and less than 2 per cent of the 2019 UNFPA humanitarian appeal of US$530 million.[307,308]

- No mechanism exists to order stock for immediate (72-hour)[309] delivery without first securing funding. Even then, due to absent or ad-hoc pre-positioning, no stock will arrive within 72 hours.

FINDINGS 21. Despite positive progress in the past decade, UNFPA still struggles to get the right people in the right place for humanitarian response on the right contractual modality.[310] The evidence of growing numbers of expert humanitarian personnel and increased humanitarian funding supports the finding that the general humanitarian staff capacity of UNFPA has improved within the last decade. However, this has failed to keep pace with increasing humanitarian needs and UNFPA global humanitarian commitments.

This evolution has shifted UNFPA from a purely development agency to one working credibly across both development and humanitarian spheres, with commitments for humanitarian responsibilities across programming and coordination linked both to its mandate (SRHR and GBV) and formalized IASC accountabilities (GBV).

At global level, UNFPA increased humanitarian human resource capacity in 2019 with the upgrading of HFCB to a full Humanitarian Office. This move has been welcomed by many stakeholders.[311] However, there is a lack of ring-fenced funding for many of the new positions[312] and some key informants in UNFPA expressed confusion as to development of the new structure and reported concerns around limited engagement in and transparency of the process.[313]

Further concerns expressed by respondents related to specific functions included in the new Humanitarian Office organizational structure.[314] Firstly, the proposed GBV team is smaller than the pre-existing (2017) team of eight.[315] Secondly, a higher number of positions are to be funded from other resources (externally dependent and therefore less secure).[316]

At regional and country levels, inconsistency of humanitarian staff resourcing was also reported as a concern. Evidence from country programmes and key informants suggests that UNFPA has, to date (and notwithstanding the planned changes within the Humanitarian Office), relied heavily on the surge mechanism for humanitarian staffing commitments. Across the board, respondents – both internal and external to UNFPA – praised the surge function.[317] The evaluation evidence indicates that expansion of surge from the initial internal roster in 2014 to include both an external roster and standby partnerships (in 2015) was an effective change, particularly given challenges to availability of internal surge roster members from existing responsibilities, but also due to the high level of humanitarian knowledge, experience and skillsets that external surge deployees bring to UNFPA.[318]

302. Lunds University. Evaluation of Strategic Stock Points for UNFPA Using a Facility Location Model. 2018.
303. UNFPA PSB key informants. For further information, refer to the thematic paper on supply-chain management for humanitarian commodities.
304. UNFPA headquarter key informants report that in 2019 UNFPA approved doubling the IARH kits held by PSB from $5 million to $10 million.
305. Lunds University. Evaluation of Strategic Stock Points for UNFPA Using a Facility Location Model. 2018 and UNFPA Copenhagen key informants.
306. Ibid.
307. UNFPA. Humanitarian Action Overview. 2019.
308. The evaluation notes that countries can procure kits with other resources they may have secured.
309. This is the IASC system-wide standard for ensuring humanitarian personnel and goods arrive in a L3 crisis.
310. Note that the thematic paper on human resources for humanitarian action has further details.
311. Ibid.
312. UNFPA. Humanitarian Office Organogram. Final. 21 March 2019. 2019.
313. Multiple UNFPA key informants. For further information, refer to the thematic paper on human resources for humanitarian action and Annex V evaluation matrix EQ6A16.
314. For further information, refer to the thematic paper on human resources for humanitarian action.
315. Multiple key informants. For further information, refer to the thematic paper on human resources for humanitarian action and Annex V evaluation matrix EQ6A16.
316. UNFPA key informants and UNFPA. Humanitarian Office Organogram. Final. 21 March 2019. 2019. For further information, refer to the thematic paper on human resources for humanitarian action and Annex V evaluation matrix EQ6A16.
317. Multiple key informants. For further information, refer to the thematic paper on human resources for humanitarian action and Annex V evaluation matrix EQ6A16.
318. Ibid.

The surge mechanism presentation for the oversight advisory committee in April 2019 highlights a 67 per cent roster growth rate between 2016 and 2018, with a 50 per cent increase in deployments across the same period. Since the external roster was launched in 2016, it has seen increasing traction, with 43 per cent of deployments being sourced from the external roster in 2018 and external roster members frequently undertaking multiple deployments.[319] There is an increasing number of French- and Spanish-speaking roster members,[320] although evaluation respondents from the LACRO region noted an ongoing shortage of Spanish-speaking roster members and that the use of English within trainings/meetings was a hindrance to engagement of national stakeholders in humanitarian responses within that region.[321]

The most pressing challenges faced by the surge mechanism identified by the evaluation are:

- Poor understanding by some country-level management as to the role and function of the surge deployees – usually linked to a limited humanitarian understanding and experience.
- Adequately balancing the proportion of a surge candidate's effort allocated to the job they are assigned vs. time spent transferring skills and capacity building country office staff.
- Management reluctance to release roster members for surge assignments elsewhere due to the absence of a mechanism to ensure that the regular duties of the surge deployees are covered.
- Logistical issues faced by external candidates who do not hold a United Nations Laissez-Passer Holders of a Laissez-Passer can usually deploy immediately without visa delays, whereas roster members travelling on national passports may have to wait weeks or months, even experiencing delays transiting through Europe or the US, significantly impeding deployment speed.[322]

Where managers are supportive of internal staff deployments to crises, there is clear acknowledgement of the benefit to that staff member vis-à-vis exposure to new contexts and increasing skills:

TABLE 5: *Deployees per mechanism 2016-2018*

% average	2016	2017	2018 Year to date
Staff	24%	30%	16%
External	N/A	36%	43%
Standby	76%	34%	41%

Source: UNFPA DHR. Surge Mechanism Presentation 10-12 April 2019.

TABLE 6: *Number of UNFPA surge deployees 2016-2018*

# of deployments by year		
2016	2017	2018
56	94	100

Source: UNFPA DHR. Surge Mechanism Presentation 10-12 April 2019.

319. UNFPA DHR. Surge Mechanism Presentation 10-12 April 2019. 2019
320. Ibid.
321. Multiple key informants. For further information, refer to the thematic paper on human resources for humanitarian action and Annex V evaluation matrix EQ6A16.
322. Multiple, key informants. For further information, refer to the thematic paper on human resources for humanitarian action and Annex V evaluation matrix EQ6A16.

The roster is an excellent mechanism that is put in place to support the UNFPA humanitarian response. Surge deployments empower and expose the staff to new environments – outside Uganda you get to know more about the UNFPA humanitarian context and I support it.[323]

Respondents have also praised the surge training – "surge training was one of best trainings I've ever had",[324] – and the support provided by the surge team. Many respondents also endorsed the move of the surge function from HFCB to the Division of Human Resources (DHR) in 2018, with a consensus that the move to the DHR has professionalized the roster and increased support for deployees and country offices[325].

The above-noted advantage to the 'home' country office of surge deployees on return, equipped with new skills, was not widely acknowledged by evaluation respondents, despite it being an evident benefit. This may represent an opportunity for UNFPA to 'market' the surge mechanism internally and externally.

Indeed, testimony from key informants of the attendance at surge training by staff members who have no intention of surging indicates the clear needs for humanitarian training not offered through any other modality within UNFPA except for such training offered from 2018 to 2019 (but discontinued due to lack of funding).[326]

FINDINGS 22. FTPs are generally viewed by UNFPA staff as useful for humanitarian response where they are activated. However, evaluation evidence indicates that FTPs are not always activated when they could be, due either to limited understanding of the procedures at country level or to concerns among country office staff responding to crises that FTPs in some way transgress overarching UNFPA policies, highlighting the prevalence of a low level of acceptance of risk at different levels. The evaluation gathered testimony from staff on the utility of FTPs in areas where they were activated.[327] For example, UNFPA **Yemen** has made considerable use of FTPs across programme management (including existing policies and procedures, allocation resources, implementation modality, engaging implementing partners and reporting), human resources, finance and procurement,[328] and reported them as critical in allowing UNFPA to respond to the crisis in Yemen as an efficient, effective and well-respected humanitarian response actor.

In **Somalia**, UNFPA has utilized FTPs and surge extensively since 2016, with examples including fast-track contracting of national partners for the drought emergency response in Puntland in 2017, which was reported as being very efficient and extensions contracts for national staff for the same response.[329] UNFPA Uganda also reported accessing FTPs effectively at the outset of a crisis response[330].

In **South Sudan**, FTPs have been in place since 2014 and have reportedly contributed to increased efficiency.[331] "I think the fast-track procedures have really improved how we do business. Two or three years ago we would not even have money to send staff into the field, but now we are able to do this."[332]

FINDINGS 23. The low level of financial risk acceptance by UNFPA undermines its overall performance as a humanitarian actor. The effectiveness of UNFPA service delivery globally is reduced by challenges with timely commodity supply. Delays result from a variety of operational issues, including the complexity of kits and their contents, leading to challenges in procurement – i.e., global stockouts of products conforming to the quality standards of UNFPA, long ordering processes and customs delays.

BOX 3: CYCLONE IDAI, MARCH 2019

Cyclone Idai hit Mozambique and Zimbabwe on Sunday 17 March. By Tuesday 19 March, UNICEF had chartered an aeroplane, filled it with life-saving commodities and it was ready to leave Copenhagen. UNICEF manage their own warehousing in Copenhagen and have a much larger humanitarian footprint than UNFPA. However, UNFPA humanitarian commodities are equally life-saving and, by Tuesday 19 March, UNFPA was still waiting for UNFPA country offices to complete assessments and place orders, which would then need approval and financing, before the order to the supplier would be submitted to check that commodities were in stock, at which point air freight would be arranged.

Information from UNFPA and UNICEF key informants, Copenhagen, March 2019.

323. Uganda key informants. For further information, refer to Annex V evaluation matrix EQ6A16.
324. UNFPA key informant.
325. Multiple UNPA key informants. For further information, refer to the thematic paper on human resources for humanitarian action and Annex V evaluation matrix EQ6A16.
326. Multiple UNFPA key informants. For further information, refer to the thematic paper on human resources for humanitarian action and Annex V evaluation matrix EQ6A16.
327. Multiple UNFPA key informants. For further information, refer to Annex V evaluation matrix EQ6A17.
328. UNFPA. Fast Track Policies and Procedures. https://www.unfpa.org/sites/default/files/admin-resource/PROG_FTP.pdf
329. For further information, refer to Annex V evaluation matrix EQ6A17.
330. Uganda key informants. For further information, refer to Annex V evaluation matrix EQ6A17.
331. South Sudan key informants. For further information, refer to Annex V evaluation matrix EQ6A17.
332. South Sudan key informant.

While lack of funding is a major constraint, stakeholders report a low risk appetite (specifically with respect to the risk of commodity wastage and therefore waste of financial resources) in UNFPA and an imbalance between prioritization of cost efficiency and a capacity to respond immediately and effectively to humanitarian crises around the world[333]. The latter would necessitate a higher stock of commodities, some of which might not be used within their projected lifespan.

The evaluation team did not obtain comprehensive supply/distribution data, precluding analysis of the different elements of this supply chain, including timeliness of UNFPA commodity provision[334]. However, qualitative evidence from respondents across multiple countries indicated significant delays with UNFPA supplies compared to other agencies – with many reporting waiting times of months between placing an order and receiving commodities.[335] An external study conducted by Lunds University on UNFPA supplies[336] concluded that "UNFPA has a considerably longer lead time than other agencies"[337] and provided information for 2015-2017 on lead times between request and dispatch. The study revealed mean lead times not aligned with a rapid response (average time between a request being submitted and commodities being dispatched from a supplier warehouse being 35 days, 49 days and 76 days, respectively, for 2015, 2016 and 2018) and have also been increasing between 2015 and 2017.[338]

Specific testimony from key informants includes:

A fundamental challenge to commodity supply – and the lack of pre-positioned stocks – is the lead time required for emergency supplies to be procured and transported by the Procurement Services Branch. For example, as part of the UNFPA response to the October 2018 [Haiti] earthquake, UNFPA, at the time of the evaluation [January 2019], was still waiting for emergency response equipment funded by Central Emergency Response Funds [CERF]; a rapid response mechanism designed to be spent within six months.[339]

A diffi culty we have is to receive the supplies which UNFPA is responsible for, from the beginning of the project. Medical kits, dignity kits – unfortunately, they arrive very late in the project. Humanitarian projects should be started with these kits, we should not have to wait for three months. It's true in almost every project, we're always confronted with this. We know that kits will arrive late. With a little money, we buy essential medicines locally.[340]

Respondents across various contexts referenced this low risk appetite in different ways:

UNFPA cannot get away from the development mindset, it always wants to control and in this process puts many layers in place, stifling capacity of staff at field level as everything needs to be approved by regional offices or headquarters…you don't need to be the best, you need to be the first…[341]

What we have is a small business that doesn't want to grow… This needs to change. Using humanitarian kits as an example: We have been entrusted with management of emergency RH kits by all the partners. I make a request; I get a quote that is guaranteed. UNICEF does it differently – they give you estimated costs only. It takes a minimum of three weeks to get a price guarantee. My people in the field are still waiting for the quote/request and by the time the product arrives the crisis may have ended. UNICEF gives estimates in 48 hours.[342]

At **country level**, UNFPA humanitarian responders can utilize FTPs and the associated Emergency Procurement Policies and Procedures[343]. These procedures aim to "enable a more timely response to urgent need for aid in emergency situations while ensuring compliance with the general procurement principles".[344] However, as discussed under finding 22 above, the evaluation noted a limited understanding at country level of FTPs as the appropriate adjunct to existing procurement protocols in humanitarian crises. This lack of awareness and/or understanding can lead to a disconnect between pre-existing UNFPA policies for emergency commodity supply and what is utilized in practice. The evaluation research did not identify any other humanitarian-specific provisions within procurement strategies or policies.[345] With insufficient overarching direction on commodity procurement in crises, country-based staff frequently default to standard, development-oriented guidelines that prioritize quality and price in procurement.

333. For further information, please refer to Annex V evaluation matrix EQ4A8
334. For further information, refer to thematic paper on supply-chain management for humanitarian commodities
335. Multiple UNFPA and other stakeholder key informants across country, regional and global levels.
336. Lunds University. Evaluation of Strategic Stock Points for UNFPA Using a Facility Location Model. 2018
337. Ibid.
338. For further information, refer to thematic paper on supply-chain management for humanitarian commodities.
339. Haiti key informant. For further information, refer to the Haiti country note, the thematic paper on the supply-chain management for humanitarian commodities and Annex V EQ4A8.
340. DRC key informant. For further information, refer to DRC country note, the thematic paper on the supply-chain management for humanitarian commodities and Annex V EQ4A8.
341. Bangladesh key informant.
342. DRC key informant.
343. https://www.unfpa.org/sites/default/files/admin-resource/PROC_Emergency%20Procurement_0.pdf, also incorporated into the FTPs
344. Ibid, section 1.1
345. For further information, refer to the thematic paper on supply-chain management for humanitarian commodities.

The FTPs do provide for faster delivery time from suppliers to be "considered" when determining value for money in procurement processes,[346] but specifics of how this may be calculated are lacking in the guidance, which is otherwise very detailed.

Further, existing FTP guidance does not provide direction for preparation for crises (for example where cyclical crises occur, such as in Haiti or Indonesia). The activation of FTPs is based on specified criteria: declared L1, L2 or L3 crises, or fragile contexts where there is a state failure to provide services[347]. These criteria are reactive in nature, and the time required to activate the FTPs after crisis onset (when response staff may face dramatically increased workloads) may hamper rapid response.

For humanitarian procurement and supply, speed has to be an equally important factor, with a resulting higher risk of loss to be expected and accepted. A (UK) Department for International Development (DFID) 2018 review stated:

Currently, the UNFPA supplies model does not take a differentiated approach to risk for delivering in acute crises or complex protracted humanitarian settings and their risk appetite is much lower than other United Nations agencies. For example, UNICEF has a "no regrets" policy when there is an emergency – they send supplies to a country whether they request them or not and without payment being received.[348]

The DFID 2018 review of UNFPA supplies in humanitarian settings reported that the UNFPA strategic plan is clear on the ambition to be a credible humanitarian player but, vis-à-vis supplies, this had yet to be "translated into tangible activity."[349]

A challenge to accurately quantifying this risk is the absence of reliable data on wastage based on over-ordering or the specific associated cost. The 2018 DFID review of UNFPA humanitarian supplies reported that "[c]urrently, commodity security branch-led work on tracking, supply chain strengthening and last-mile delivery does not consider areas experiencing or at risk of humanitarian crises."[350] APRO report some limited data on wastage in the context of preparedness, which was minimal (albeit in relation to pre-positioning non-perishable items such as dignity kits).[351] There is also no evidence of what acceptable loss looks like for UNFPA. Until a more robust monitoring system is in place to understand what wastage is occurring, a formula for acceptable loss and associated risk appetite is not feasible.[352] However, a shift in thinking is needed to accept greater risk and accept that more speed implies more losses/wastage.

More robust data on commodity monitoring exists, however, at the regional level, notably within APRO. UNFPA APRO has a regional pre-positioning initiative which is reported as being "a game changer"[353] in the timeliness and effectiveness of UNFPA humanitarian response within the region. In 2017-2018 (the second year of the project), UNFPA distributed a total of US$784,159 worth of supplies across eight emergency responses in seven countries, directly reaching an estimated 55,000 people. APRO monitoring data related to the commodities indicates a saving of US$60,905 by transporting supplies for pre-positioning by sea rather than by air.

While the low appetite for risk is demonstrated most obviously through the UNFPA approach to humanitarian supplies, it impacts all humanitarian programming and must be addressed for UNFPA to move to the next level of humanitarian response expertise and credibility.

FINDINGS 24. At country level, strong partnerships with government, sister agencies, NGOs and CSOs are a cornerstone of UNFPA development programming. Such robust partnerships can be a considerable advantage in humanitarian response. However, UNFPA has no standardized method of leveraging these partnerships across all humanitarian action areas, nor with other partners such as academic institutions or the private sector. The evaluation has identified consistent evidence across all countries of strong partnerships with government ministries and departments at national and sub-national levels. Further, UNFPA consistently seeks to support humanitarian programming through national civil society actors where possible.

For example, in **Ukraine**, UNFPA has focused and strong partnerships with state entities for SRHR and with state entities and NGOs for GBV. The 2018-2022 Ukraine CPD notes that UNFPA will "seek to create broad-based partnerships, at national and sub-national levels, to deliver and sustain the planned results … Civil society and academia have been long-standing partners for UNFPA and partnerships with United Nations agencies will be pursued where synergies are cost-effective. UNFPA will also seek to establish partnerships with the media and the private sector, based on shared values and comparative advantages. The country office will continue to promote national implementation as the preferred mode of delivery."[354]

346. See UNFPA Fast Track Procedures, Revision 2: August 2015: Section 5.4
347. See UNFPA Fast Track Procedures, Revision 2: August 2015: Section 1.2
348. DFID. Review of UNFPA Supplies in Humanitarian Settings, May-August 2018. 2018.
349. DFID. Review of UNFPA Supplies in Humanitarian Settings, May-August 2018. 2018.
350. Ibid.
351. UNFPA key informant.
352. UNFPA has recently initiated a Last Mile Assurance process, designed to provide better data in this regard – refer to UNFPA. Management Response to the Report of the Office of Audit and Investigation DP/FPA/2019/CRP.6.
353. UNFPA. Regional Prepositioning Initiative Annual Progress Report. 2018.
354. UNFPA. Ukraine CPD 2018-2022. 2018.

In **Yemen**, UNFPA partners with sister United Nations agencies, government, civil society and the private sector. In 2018, UNFPA noted key learning on partnerships with local businesses to deliver reproductive health supplies. These enhanced efforts to reach affected people in remote areas, despite blockages and lengthy custom clearance.[355] National NGOs have proved to be reliable partners with easier access to the conflict areas and the populations. However, national NGOs have lacked sufficient technical capacity for effective GBV response and have required a lot of capacity support.

In **Haiti**, UNFPA has leveraged strong partnerships across government, other United Nations agencies and civil society. However, the 2013-2016 country programme evaluation noted that (1) implementing partners were not specifically trained to respond to emergencies and (2) UNFPA did not identify a specific partner training agency to develop response capacity. As a result of these findings, UNFPA has increased provision of training on SRH, GBV and data in humanitarian settings.[356]

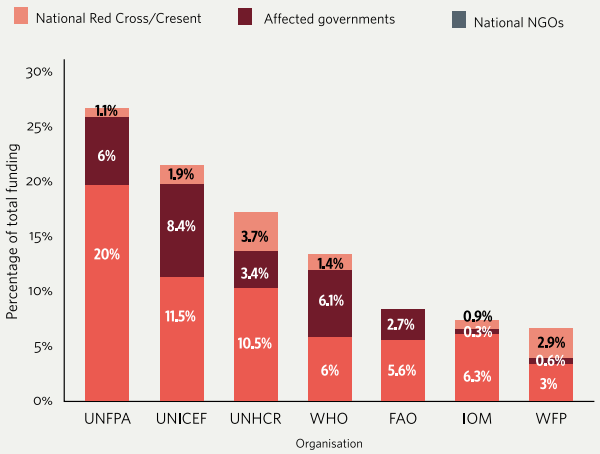
In **Indonesia**, there is ample evidence of UNFPA instituting and maintaining strong relationships with many government and non-government partners. This gives UNFPA an advantage in humanitarian response, positioning them well to work on sensitive RH issues. For the NTB and Central Sulawesi responses of 2018, UNFPA was formally invited by the national government to lead the response on RH and GBV soon after each disaster struck, even when some other international actors were reportedly disallowed or discouraged from getting involved in humanitarian assistance. This meant, in Central Sulawesi, that UNFPA deployed midwives within one week and positioned the first tent within the second week.

While the evaluation has identified consistent evidence of strong partnerships with government ministries and departments at national and sub-national levels there is limited evidence of UNFPA consistently and strategically leveraging CSOs, academic institutions, or private sector partnerships with consideration of how best these different entities can reach populations (coverage) with interventions meeting minimum global standards (quality) in the most efficient manner (value for money), while building civil society capacity for sustainability (collective outcomes across the NWoW).

A 2015 report on the localization agenda highlighted UNFPA as having the highest percentage of CERF funds sub-granted to national NGOs.

Such (relatively) substantial support to localization of aid demonstrates good practice per the NWoW. More information is necessary to analyse how UNFPA is seeking partnerships with local CSOs and national NGOs to further the Grand Bargain localization agenda because evidence from this evaluation did not demonstrate any coherent strategy for this, with more emphasis across all countries placed on partnerships with government at national and provincial levels across most countries.

FIGURE 7: *United Nations entities' CERF sub-grant allocation to local and national responders 2015*



Source: Local to Global. Funding to Local and National Humanitarian Responders: Can Grand Bargain Signatories Reach the 25% Target by 2020? 2017. https://www.local2global.info/wp-content/uploads/L2GP_GrandBargainSignatories_commitment_full_Report_FINAL.pdf

355. UNFPA. Delivering Supplies When Crisis Strikes. 2018

356. UNFPA. Haiti Humanitarian Coordinator Final Report December 2018. 2018.

EVALUATION QUESTION 7:
COORDINATION

To what extent does formal leadership by UNFPA of the GBV AoR and informal leadership of RH working groups and youth working groups contributed to an improved SRH, GBV and youth-inclusive response?

FINDINGS

25. The GBV AoR at the global level has progressed positively since UNFPA assumed sole leadership in 2017. In 2019, it has been adequately resourced for the first time but this has not been wholly based on core resource commitment from UNFPA.

26. At the country level, coordination by GBV sub-clusters has improved but there remain GBV sub-clusters which are under-resourced, with double-hatting coordinators, an absence of information management functions and an over-reliance on surge.

27. There is clear evidence of reproductive health working groups at the country level having a positive impact on health programming. However, reproductive health working groups remain ad hoc with no systematic establishment, resourcing, or scope and function.

28. UNFPA global commitment to youth leadership through the Global Compact for Young People in Humanitarian Action has not trickled down to country-level leadership or coordination.

FINDINGS 25. The GBV AoR at the global level has progressed positively since UNFPA assumed sole leadership in 2017. In 2019, it has been adequately resourced for the first time in 2019 but this has not been wholly based on core resource commitment from UNFPA.[357] The GBV AoR, established in 2006, is the global level forum for coordination and collaboration under the cluster approach on GBV prevention and response in humanitarian settings. Since 2016, when UNFPA began the transition toward assuming sole responsibility for leadership of the AoR, evidence from key informants and GBV practitioners engaged in humanitarian programming indicates that the AoR has progressed positively. Some key milestones achieved under the leadership of UNFPA since 2016 are:

- Development of a new AoR vision, mission and strategy
- Engagement in facilitating the direction for the 2019 Oslo Global GBV meeting[358]
- Development of revised GBV coordination handbook and roll-out in Yemen and Libya[359]
- Development of global minimum standards for GBV in collaboration with UNFPA GBV staff[360]
- Strong engagement with the global Call to Action initiative with the AoR piloting the implementation of two Call to Action national roadmaps in Nigeria and DRC[361,362]
- Support for a community of practice and a GBV AoR helpdesk
- Work on improving GBV data and information management from the previous narrow focus on GBVIMS to a broader understanding of data required for humanitarian needs assessments, response plans, dashboards and reporting.

These achievements have all been positive, although accomplished with some, albeit limited, core resource support from UNFPA. The GBV AoR is hosted in the UNFPA

357. Note that a transition period for UNFPA to assume sole leadership of the GBV AoR (previously jointly led by UNFPA and UNICEF) began in April 2016 and the GBV AoR Strategy states "The United Nations Population Fund (UNFPA) has been the lead Agency of the GBV AoR since April 2016." However, April 2016 to March 2017 was a transition period, with UNFPA reporting a formal assumption of leadership of the AoR in March 2017. https://gbvaor.net/sites/default/files/2019-07/GBV%20AoR%20Strategy%202018-2020%20P3.pdf

358. https://www.endsgbvoslo.no

359. Just launched in June 2019: http://gbvaor.net/handbook-coordinating-gender-based-violence-emergencies-now/ and UNFPA key informants.

360. The process of the Minimum Standards has been led by UNFPA Staff with funding secured by the GBV AOR: UNFPA key informants.

361. https://www.calltoactiongbv.com

362. UNFPA key informants.

Geneva office, with currently six team members[363] (similar to other global AoRs/clusters) but only one position (the coordinator) directly funded by regular resources and this since 2018 only. All other positions are (temporarily) supported with funds raised directly by the AoR. In the mid-2019 draft UNFPA Humanitarian Office organizational structure, five GBV area of responsibility positions are included: coordinator (P5) and GBV specialist (P4) both core-funded and then other resources-funded positions of deputy coordinator (P4) and two P2 programme analysts, which will provide useful security of tenure that will benefit the AoR for the future.

FINDINGS 26. At the country level, coordination by GBV sub-clusters has improved but there remain GBV sub-clusters which are under-resourced, with double-hatting coordinators, an absence of information management (IM) functions and an over-reliance on surge. However, the evaluation did identify examples of effective GBV sub-clusters that are well-resourced (with resourcing at both adequate numbers and levels of expertise) and contributing to an improved GBV response aligned with global standards.

In **Yemen**, UNFPA leads a well-coordinated and functioning GBV sub-cluster that respondents confirmed has contributed to the protection cluster and overall priorities through the HNO and HRP processes. GBV and child protection sub-clusters coordinate for child marriage and FGM programming. There is a dedicated GBV sub-cluster coordinator (P4 level) which has contributed to the sub-cluster effectiveness despite the conservative environment of Yemen. Respondents noted positive contributions of the sub-cluster on sensitive issues, which would be more difficult on the part of individual agencies.[364] For example, it was reported that "CMR is not acceptable to the local authorities, but through the GBV sub-cluster platform we could all coordinate and come up with a definition that was acceptable to the local authorities and allowed us to achieve our objectives. We were, together, able to contextualize and localize the terminology. This was the only platform to achieve that."[365]

In **Turkey**, evidence from respondents and secondary research indicates the 50-member cross-border GBV sub-cluster functions well. Respondents across the board noted that the sub-cluster provides a mechanism for reducing geographical gaps and avoiding duplication, capacity building in both GBV and humanitarian principles and standards, setting minimum standards in line with global guidance for GBV programming, fundraising and advocacy with a common voice and goal. The GBV sub-cluster has had an annual strategy since 2015 and UNFPA has invested heavily in capacity building of members, data management through the GBV dashboard; and qualitative data (the annual Voices report)[366] for both programme design and advocacy purposes.[367]

In **Bangladesh**, UNFPA leads GBV coordination at national level under the Humanitarian Coordination Task Team and in Cox's Bazar under the Protection Sector.[368] UNFPA has resourced the 28-member GBV sub-sector with a dedicated coordinator who is independent of the GBV team and an information officer who double-hats across coordination and UNFPA programming roles.[369] Since 2018, the GBV sub-sector in Cox's Bazar has contributed to an improved response by:

- Developing technical guidance on setting up women- and girl-friendly spaces with partners
- Creating minimum standards checklists and initiating a service audit to enhance referral systems
- Introducing a dignity kit guidance document to enable item standards and established mechanisms for aligning kit distributions
- Conducting a multi-sector service audit via existing GBV services and facilities to support the development of referral pathways at the zonal level
- Developing a GBV sub-sector strategy[370]
- Maintaining a GBV 5W dashboard.[371]

However, strong examples of fully resourced GBV sub-clusters (i.e., through contracting modalities outside of surge) are limited. In many other contexts, GBV coordination suffers because of the shortage of adequate resourcing (dedicated positions at the right level and on the right contracting modality covering coordination and information management functions).

363. GBV AoR key informants. For further information, refer to Annex V evaluation matrix EQ7A19.
364. Multiple key informants. For further information, refer to the thematic paper on human resources for humanitarian action and Annex V evaluation matrix EQ7A19.
365. Yemen key informant.
366. https://reliefweb.int/sites/reliefweb.int/files/resources/gbv.pdf
367. Turkey key informants. For further information, refer to Annex V evaluation matrix EQ7A19.
368. UNFPA. Bangladesh Annual Report, 2017. 2017.
369. UNFPA key informants. For further information, refer to Annex V evaluation matrix EQ7A19.
370. UNFPA. Bangladesh Annual Report, 2017. 2017. and https://www.humanitarianresponse.info/en/operations/bangladesh/gender-based-violence-gbv
371. The 5W dashboard is a standardized way of mapping services and activities, used across all clusters/sectors and including Who, does What, Where, When and for Whom.

In **South Sudan**, the UNFPA-led 60-member GBV sub-cluster was first introduced in 2010. As of the end of 2018, it was co-led by UNFPA and International Medical Corps.[372] However, respondents reported gaps in human resource support and difficulty in ensuring that the GBV coordinator position is filled by someone who is able to stay on for more than a short period of time.[373]

In **Chad**, double-hatting was highlighted by multiple key informants as something that negatively impacts coordination work within humanitarian settings.[374]

In **Somalia**, UNFPA facilitated the establishment of 12 inter-agency GBV working groups between 2010 and 2015. The sub-cluster and working groups coordinate closely with the federal and regional governments and were the driving force behind policy reforms and contributed to the HNO and HRP processes.[375] However, until 2019 there was no dedicated sub-cluster coordinator and respondents attested that this diminished some of the achievements of the sub-cluster strategic advocacy efforts.[376]

In **Ukraine**, the GBV sub-cluster – operational since 2015 – is strong, well-attended and highly functional with committed co-leadership from government and engaged participation by members. There was a dedicated international GBV coordinator in 2016-2017 and, since then, the cluster has been competently led by a double-hatting national GBV advisor. However, other clusters have maintained international dedicated coordinators for their cluster responsibilities and the global commitment of UNFPA is to lead and resource GBV at the same level as other agencies lead and resource other clusters.[377]

In **DRC**, coordination of the GBV sub-cluster at both national and sub-regional levels is strong but many functions, such as the implementation of standard operating procedures and promotion of the IASC GBV Guidelines to other agencies, require further attention. In 2017, UNFPA became the coordinator of the new GBV sub-cluster. There are now functioning sub-clusters at the national and sub-national levels. However, as of the time of research, there were no clearly understood standard operating procedures in place (although the sub-cluster reported plans to disseminate GBV standard operating procedures in 2019)[378] nor widespread training or technical support to sectors on the GBV guidelines.[379] Many respondents highlighted concerns around GBV sub-cluster double-hatting or triple-hatting (with PSEA responsibilities): "Re GBV sub-cluster coordination – it's not a lack of goodwill, but a lack of time – too many tasks for one person to respond to all the needs."[380]

Haiti presented evidence of strong UNFPA GBV sub-cluster leadership during Hurricane Matthew in 2016 but there is limited evidence of consistent well-functioning coordination since then. There is no clear evidence of strong UNFPA leadership within the GBV sectoral group, which is a standing (but relatively inactive) coordination mechanism that becomes activated during emergencies. Some respondents reported UNFPA demonstrating good leadership of the GBV sub-cluster during Hurricane Matthew due to the presence of dedicated UNFPA GBV coordination staff.[381]

In **Nigeria**, UNFPA annual reporting for 2017 and 2018 notes improvements in interagency GBV coordination across the humanitarian response as well as with the military. The majority of evaluation respondents attested to the high quality of UNFPA coordination of the GBV but feedback from several GBV sub-cluster members highlighted a perception of weakness within UNFPA leadership, partly due to the post of sub-cluster coordinator being annually filled via surge.[382]

There are six core functions of a cluster at country level covering (a) support to service delivery; (b) informing HCT strategic decision-making; (c) planning and implementing cluster strategies; (d) monitoring and evaluating performance; (e) building national capacity; and (f) supporting advocacy.

In those contexts, with dedicated international P4 or P5 coordinators and IM support (such as Yemen, Bangladesh and Turkey), GBV sub-clusters have the capacity to be more able to meet all six required functions of coordination. In other contexts, only some of the functions are being achieved. In Ukraine, for example, the GBV sub-cluster fully achieves function 1 – service delivery (in government-controlled areas). However, there are elements of all the other functions that are not currently achieved in these areas and none of the functions are achieved along the contact line or in non-government-controlled areas. Some functions – such as informing HCT strategies – would be more easily achieved with a dedicated coordinator at the same level of experience as other clusters.[383] In Somalia, function 2 – informing the strategic direction of the HCT – is highlighted as missing.[384] In DRC, the response has been missing focus on consistent standards – standard operating procedures and global minimum standards – such as the IASC GBV

372. Changing to be co-led by UNFPA and the International Rescue Committee (IRC) in 2019.
373. South Sudan key informants. For further information, refer to Annex V evaluation matrix EQ7A19.
374. For further information, refer to Annex V evaluation matrix EQ7A19.
375. UNFPA Somalia. Gender Annual Report. 2016
376. For further information, refer to Annex V evaluation matrix EQ7A19.
377. Ibid.
378. DRC key informant.
379. DRC key informants. For further information, refer to Annex V evaluation matrix EQ7A19.
380. DRC key informant.
381. Haiti key informants. For further information, refer to Annex V evaluation matrix EQ7A19.
382. For further information, refer to Annex V evaluation matrix EQ7A19.
383. Ibid.
384. Ibid.

guidelines, which constitute a core part of function 3.[385] In Haiti, without an effective GBVIMS, there is a lack of function 4, related to monitoring and reporting against activities and needs.[386]

A double-hatting coordinator can rarely manage a coordination role to the same level of all other clusters, which are, generally, resourced with an international dedicated coordinator. This inhibits the ability of the GBV sub-cluster as a whole to access centralized funding, to advocate for GBV prevention and response measures, to roll out training and GBV minimum standards or to have a solid voice within inter-cluster coordination platforms and therefore influence the direction of the response in a way which benefits women and girls.

FINDINGS 27. There is clear evidence of reproductive health working groups at the country level having a positive impact on health programming. However, reproductive health working groups remain ad hoc with no systematic establishment, resourcing, or scope and function of reproductive health working groups. Respondents report that SRHR programming expertise is generally more embedded than GBV expertise within country offices, with SRHR being a core development programme area for UNFPA in a way in which GBV is not.[387] Respondents have suggested that, until more recently, many UNFPA staff believed UNFPA humanitarian response accountability was limited to MISP.[388]

In terms of staffing, the greater capacity of UNFPA country offices with respect to longer-term SRHR programming typically supports a faster transition to sub-working group coordination activities if/when needed. Further, UNFPA often supports RH working groups focused on longer-term development. Existence of these facilitates emergency response RH working groups (with many actors working across both spheres) and also faster transition from crisis back to longer-term development goals.[389]

Evidence from multiple country contexts and from primary and secondary data sources indicates an impressive promotion of MISP across UNFPA and partner staff before, during and after emergencies.

However, SRHR is not an IASC-established area of responsibility under the health cluster and, as such, SRHR working groups (typically termed 'RH' working groups) are established informally by UNFPA at the discretion of WHO (which leads the health cluster). As a result, RH working groups are inherently ad hoc with no mechanism for systematic establishment or resourcing.

Among the humanitarian responses sampled for this evaluation, several made no reference to existing or previous RH working groups (i.e., Chad, Colombia, Haiti and Ukraine). Those country contexts where working groups had been established (e.g., Indonesia, Colombia) presented clear evidence of the value they add to humanitarian responses.

For example, in **DRC**, the operational RH working group has well-defined terms of reference that include objectives, activities and expected results.[390] UNFPA had also established sub-national-level RH working groups, which UNFPA co-leads with another agency, generally an international or national NGO with presence in the region. An emphasis on rapid response using the MISP and CMR guidelines is top priority, especially when new crises arise).[391] Among the other topics that have been featured at health cluster meetings in DRC are presentations on the overall importance of reproductive and maternal health and the different RH kits available.[392] At the RH working group's own meetings, activities include mapping of each member NGO skillsets and geographic coverage; sharing emergency alerts, gaps and responses required among the members; priority setting; capacity building of members in the MISP; and planning joint needs assessments or field visits.[393]

In **Indonesia**, UNFPA has been a long-standing and key coordination partner for RH at the national level and has leveraged that relationship to support RH coordination in humanitarian responses. UNFPA worked with the Government of Indonesia as early as 2014 to initiate a national RH response team. When the Government decree on initiating a cluster system for humanitarian response was endorsed, the Ministry of Health was designated to lead the National Health Cluster and the RH sub-cluster, with which UNFPA was very engaged. In 2016, a national RH team comprised of sub-cluster partners, including UNFPA, was established. All of this work meant that, when the recent crises occurred, UNFPA and the Ministry of Health could promptly activate a response.[394]

In **Yemen**, multiple stakeholders attested to UNFPA leading a well-coordinated and functioning RH working

385. Ibid.

386. Ibid.

387. Multiple key informants. For further information, refer to the thematic paper on human resources for humanitarian action and Annex V evaluation matrix EQ7A20.

388. UNFPA regional and headquarter key informants.

389. UNFPA regional key informants.

390. UNFPA. Termes de Reference du Groupe de Travail Santéde la Reproduction. (no date).

391. Several of these more recently established RH working groups have included the term 'sexual and reproductive health' in their names. See documents titled Termes de Reference Group de Travail Santé Sexuelle et Reproductive (GT/SSR) de Kananga and Termes de Reference group de Travail Santé Sexuelle et Reproductive (GT/SSR) de la Région du Kasaï.

392. Multiple DRC key informants. For further information, refer to DRC country note and Annex V evaluation matrix EQ7A20.

393. UNFPA. Termes de Reference du Groupe de Travail Santé de la Reproduction. (no date).

394. Multiple key informants. For further information, refer to the Indonesia country note and Annex V evaluation matrix EQ7A20.

group[395] that plays a prominent and integrated role within the health cluster. However, respondents also noted that a better mutual understanding of mandates between UNFPA and WHO would result in more systematic coordination. Evidence from stakeholders and secondary data indicates that the 30-member RH working group has improved over time with increased participation by and focused coordination among, partners of the larger health cluster.[396]

Coordination of MISP for reproductive health has greatly improved in Southern Yemen as a result of the launch and establishment of the Aden Hub Sub-National RHIAWG on 14 February 2018. Co-chaired with the Ministry of Health, RHIAWG has brought together over 20 national and international NGOs working on reproductive health in Southern Yemen and strengthened MISP implementation capacity through ongoing training. The RHIAWG Coordinator organized three MISP learning sessions – one every month – conducted during monthly RHIAWG meetings.[397]

In **Turkey**, evidence from key informants and documentation indicates that the RH working group for cross-border coordination forum for SRH functions well, despite limited resources allocated by UNFPA and the complexity of the cross-border response from Gaziantep. The RH working group, established by UNFPA in 2015, has concentrated on capacity building for the provision of quality services inside Syria, within broader strategic plans and of membership. At the time of the evaluation research, the RH working group was concluding a comprehensive 18-month training for midwives, which was described by respondents as "very strong with a lot of hands-on leadership from UNFPA" and operating under "UNFPA guidance [which is] quite outstanding to partners."[398] The RH working group has a national Syrian NGO co-lead position (Physicians Across Continents between 2016 and 2018 and the Syrian Expatriate Medical Association between 2018 and 2019), which respondents report adds good value.[399]

In **Bangladesh**, the health sector for the Rohingya refugee response (in Cox's Bazar) is coordinated overall by the Government Civil Surgeon's Office, the Directorate General of Health Services Coordination Centre and WHO. The 53-member SRH working group,[400] established in 2017 and coordinated by UNFPA, has a dedicated coordinator and a (double-hatting) information management officer who works across the coordination function and UNFPA SRH programming. Partners report it being a useful platform.[401] There is evidence that the SRH working group has undertaken a range of activities that have contributed to increasing the effectiveness of SRHR programming in the context of the humanitarian response in Cox's Bazar, such as:

- Coordinating distribution of emergency RH kits to implementing partners and government facilities
- A community-based retrospective study of maternal mortality to provide a baseline for more robust maternal mortality surveillance in the camps in 2019
- Development of service quality monitoring checklists for health providers with trainings to improve the quality of SRH/MNH care provided to refugees and the local population
- Development of a pool of master trainers on key SRH topics for front-line service providers.[402]

In **South Sudan**, health actors started coordinating CMR services through the RH working group under the health cluster in 2019, although, as far back as 2012, UNFPA conducted refugee camp assessments to ensure RH coordination was integrated into health services coordination. GBV sub-cluster members that provide health services participate in both groups because there are insufficient trained medical personnel to handle CMR and basic PSS during medical intake.[403]

An example of a country context without an RH working group is **Ukraine**. In 2014, a joint UNFPA and International Planned Parenthood Federation (IPPF) MISP readiness assessment highlighted that Ukraine was not at an acceptable readiness level to meet basic international standards for SRHR in humanitarian response.[404] In the same way that UNFPA has leveraged the GBV sub-cluster within Ukraine to jump-start a national discussion on GBV, a functioning RH working group would use the response to the crisis to promote increased quality of maternal and newborn, GBV clinical response and HIV/STI diagnosis and treatment within the state healthcare system. This is not promoted under the WHO-led Health Cluster, which, in 2018/19, prioritized mental health and PSS. For SRHR issues to be prioritized, UNFPA would have to take a more active leadership role.

395. Yemen key informants. For further information, refer to Annex V evaluation matrix EQ7A20.
396. Ibid.
397. UNFPA. Emergency Funds Report. 2018.
398. Turkey key informants. For further information, refer to Annex V evaluation matrix EQ7A20.
399. Ibid.
400. Note that Bangladesh is the only country within this evaluation to term the working group SRH rather than RH.
401. Bangladesh key informants. For further information, refer to Annex V evaluation matrix EQ7A20.
402. Ibid.
403. GBV Sub-Cluster Strategy South Sudan, 2017.
404. UNFPA and IPPF. Assessment of countries' readiness to provide Minimum Initial Service Package for SRH during a Humanitarian Crisis in the Eastern Europe and Central Asia Region. 2014

Even without a global SRHR Area of Responsibility, UNFPA is globally considered to be the lead United Nations agency for SRHR in both development and humanitarian settings, based on the UNFPA mandate (but not IASC-endorsed accountability as agency of last resort). Therefore, even without a formalized SRHR sub-cluster at country level, the ideal situation within a clustered setting is for there to be an RH working group to ensure that, within the humanitarian response, actors are striving to ensure people access SRHR services according to global minimum standards. This is, in fact, the first objective of MISP, which is articulated as "[e]nsuring the health cluster identifies an organization to lead implementation of the MISP – the lead SRH organization."[405] This is the mandated responsibility of UNFPA. In addition to being a MISP requirement, an RH working group also allows a humanitarian crisis to be an entry point for increasing levels of knowledge about internationally-accepted minimum standards for SRHR and how these link across the cluster system.

The evaluation notes ongoing debate at the global level as to whether SRHR should become a formalized AoR (under the leadership of UNFPA) under the health cluster.[406] Some specific concerns highlighted by respondents include whether this could lead to further health AoRs (e.g., mental health and PSS), complicating the coordination structure. However, it is almost universally accepted by SRHR humanitarian actors, including UNFPA staff, that a working group for SRHR needs of women and girls – either formalized as a sub-cluster or remaining an informal platform under health (the current model in most settings) – is necessary during a crisis.[407]

Further, the evidence indicates that coordination of RH commodity ordering and distribution at field level (an activity normally undertaken within the RH working group at country level) is not systematic. IARH kits are available to order both internally (by UNFPA country offices) and externally (by other partners). Currently, there is no adequate mechanism to coordinate ordering. The 2018 DFID review highlighted that UNFPA has an inter-agency role in this regard but "struggled to get complete clarity on the current systems."[408] The evidence of this evaluation reinforces this finding. UNFPA PSB key informants report no centralized mechanism to ensure order coordination.[409] Respondents assumed it is addressed at country level, although no systematic mechanisms for ensuring this were noted by the evaluation. Indeed, PSB respondents provided examples of non-UNFPA actors ordering for specific countries without the knowledge of relevant country offices.[410]

FINDINGS 28. UNFPA global commitment to youth leadership through the Global Compact for Young People in Humanitarian Action has not trickled down to country-level leadership or coordination. UNFPA, together with the International Federation of the Red Cross, is the global co-lead for the Compact for Young People in Humanitarian Settings.[411] UNFPA key informants report an understanding that the youth leadership role for UNFPA is still emerging, despite the fact that the compact was established after the WHS in 2016, (three years prior to this evaluation research). UNFPA also has a leadership role linked to UNSCR 2250[412] on youth, peace and security, with the development of the progress report (as referenced in the Introduction to this report).[413]

These two leadership roles together suggest UNFPA emerging as a clear youth coordination voice. However, across the 15 countries included within this evaluation, no established national humanitarian youth coordination groups were identified. The evaluation noted examples of discrete youth programming at different levels (national/sub-national) and across different contexts, but almost no youth coordination to match the global commitments UNFPA has assumed.[414]

Examples of localized youth coordination efforts by UNFPA and efforts to ensure that SRHR programming and GBV programming remain youth- and adolescent-inclusive, include DRC, where two working groups exist on adolescents and youth: one for all actors, led by government; the other just for United Nations agencies. However, a 2016 evaluation of a DRC programme jointly funded by Canada and Sweden identified the general lack of coordination on youth issues[415] and reached a similar conclusion as this evaluation: that UNFPA (and UNICEF and UN Women) were all targeting adolescents and youth as part of their core mandate and programming, but that there was no clear division of roles and responsibilities.

405. Updated MISP: http://iawg.net/wp-content/uploads/2019/01/MISP-Cheatsheet.pdf

406. Multiple key informants. For further information, refer to Annex V evaluation matrix EQ7A20.

407. Multiple key informants. For further information, refer to Annex V evaluation matrix EQ7A20.

408. DFID. Review of UNFPA Supplies in Humanitarian Settings, May-August 2018. 2018.

409. PSB reports the internal to external ratio for RH kits is approximately 80 per cent internal to 20 per cent external.

410. UNFPA PSB key informants. For further information, refer to Annex V evaluation matrix EQ7A20.

411. https://www.agendaforhumanity.org/initiatives/3829

412. https://www.un.org/press/en/2015/sc12149.doc.htm

413. https://www.unfpa.org/youth-peace-security

414. The evaluation notes that guidelines for implementation of working with and for young people in humanitarian action were only developed in 2018. However, the evaluation matrix requires a consideration of UNFPA leadership since this role was assumed in 2016 regardless of the availability of guidelines.

415. End Line Evaluation of the H4+Joint Programme Canada and Sweden (Sida) 2011-2016 – DRC.

This points to significant weakness in the design and programming of interventions, caused by a lack of vision for a comprehensive and evidence-based package of adolescent and youth...services and education.[416]

Work with young people by UNFPA to promote the peace is important. This helps but we need a more holistic approach. Is UNFPA coordinating with other actors doing this work? Don't just do an isolated activity but embed it into other work on peaceful coexistence.[417]

In **Somalia**, while there is no UNFPA leadership of a youth coordination mechanism, UNFPA has rolled out the Y-PEER network and coordinates with national entities such as youth ministries.[418,419] Secondary research provides evidence of UNFPA work in establishing a youth forum;[420] of contributions of the Y-PEER network to an environment where young people can discuss issues like FGM, HIV, early marriage and GBV; organize activities in their schools; and of support for celebrations such as the International Day of Health.[421] UNFPA respondents noted that youth are not treated as a standalone theme and that the Adolescent SRH group is included as part of the RH working group.[422]

In **Bangladesh**, a youth working group established under the education sub-sector is co-chaired by UNFPA and Plan International. This working group plays a coordinating role among all actors working on adolescent and youth issues. It has also developed a 4Ws database.[423]

In **Indonesia**, there is no national coordination mechanism for youth, but UNFPA established a working group on adolescents for one crisis response (Central Sulawesi in 2018) to facilitate coordination of youth activities. At the national level, UNFPA shared plans to introduce a Youth Coordination Forum under the RH working group, although one respondent expressed the concern that this might reinforce the problem that adolescents are "only acknowledged by the health sector in Indonesia."[424]

These disparate and sub-national examples reinforce the fact that UNFPA has not facilitated youth coordination at national levels for humanitarian response and has, to date, not lived up to its commitments under the Compact for Young People in Humanitarian Action assumed in 2016.

416. Ibid, p. 61

417. DRC key informant. For further information, refer to DRC country note and Annex evaluation matrix EQ7A21.

418. For further information, refer to Annex V evaluation matrix EQ7A21.

419. The Youth Peer Education Network, Y-PEER, aims to promote healthy lifestyles and to empower young people at different levels through peer to peer approach. Y-PEER was created by UNFPA and UNICEF and was launched in 1999 Y-PEER is a development network but has been used by UNFPA in many different fragile/humanitarian contexts: http://www.y-peer.org/about/history/

420. Somalia Country Programme Evaluation, 2016.

421. UNFPA Somalia Annual Report, 2018.

422. Ibid

423. For further information, refer to Annex V evaluation matrix EQ7A21.

424. Indonesia key informant. For further information, refer to the Indonesia country note and Annex V evaluation matrix EQ7A21.

EVALUATION QUESTION 8:
CONNECTEDNESS

To what extent does UNFPA humanitarian programming take account of and align with longer-term needs and root causes of crises and development and peace programming (both by UNFPA and partners and other actors) and work to enhance the capacity of national and local actors (particularly women and youth CSOs)?

FINDINGS

29. There is evidence that UNFPA is successfully taking a continuum approach across the humanitarian and development nexus at country, regional and global levels. However, UNFPA has not successfully bridged the humanitarian-development-peace triple nexus and has not systematically fulfilled its global obligations vis-à-vis UNSCR 2250 at country level.

30. There is significant evidence that UNFPA works closely with government as a national actor to build capacity for sustainability in humanitarian programming. At the same time, there is evidence in many of the countries examined for this evaluation that UNFPA works closely with local organizations for GBV work, particularly in the area of PSS, but without systematically targeting women's organizations.

FINDINGS 29. There is evidence that UNFPA is successfully taking a continuum approach across the humanitarian and development nexus at country, regional and global levels. However, UNFPA has not successfully bridged the humanitarian-development-peace triple nexus and has not systematically fulfilled its global obligations vis-à-vis UNSCR 2250 at country level. The evaluation has identified good evidence of a continuum approach by UNFPA to humanitarian/development work despite the challenge in ensuring that staff have the skills and capacities to be able to work across the nexus. This challenge covers different phases of humanitarian action including:

- Preparedness, DRR and resilience-building interventions as aspects of humanitarian action which are undertaken by development staff with development funding in development settings
- Humanitarian response itself
- An understanding of how humanitarian response should be linked to longer-term (collective) outcomes and transition through early recovery back to normality and stronger development work.

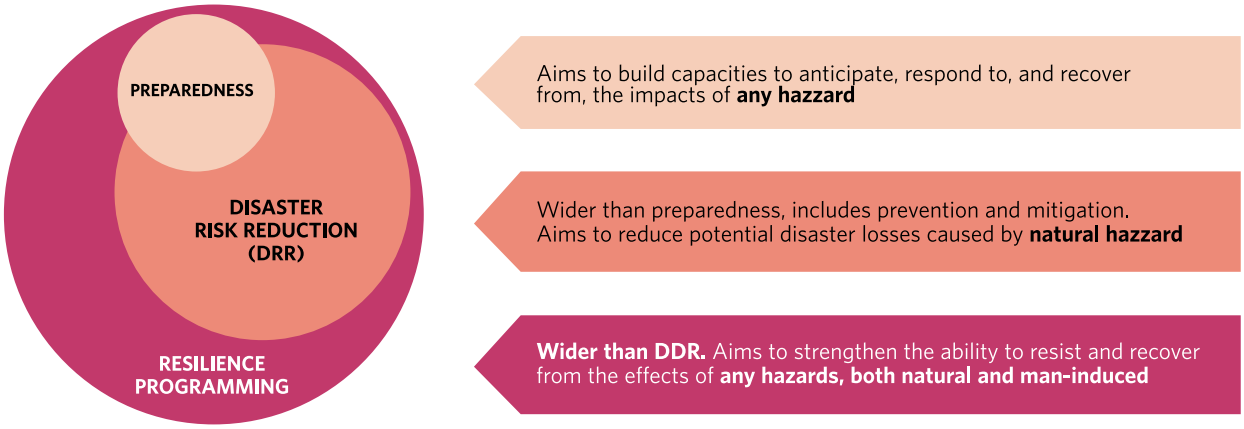
The issues UNFPA faces with releasing internal surge staff contributes to the challenge of ensuring that staff have the skills and capacities to be able to work across the nexus, as does the limited number of humanitarian specialists across UNFPA at all levels.

The 2017 UNFPA standard operating procedures for the management of emergency surge deployments state that "[w]hile UNFPA considers its own staff as its 'first line of defence' during an emergency situation, the unpredictable nature and increasing number of humanitarian disasters has prompted us to think more strategically on how to manage our surge response..."[425] This more strategic thinking led to an increase in standby partners and external roster candidate deployments which, as previously noted, has significantly increased the effectiveness of UNFPA surge capacity. However, it has had limited effect on increasing the internal capacity of UNFPA own staff as 'first line of defence'.

Country offices are responsible for ensuring emergency preparedness within UNFPA country programme design and national development frameworks, in line with the UNFPA guidance on MPAs and UNFPA positioning on DRR. This guidance[426] notes that preparedness not only ensures more timely and effective emergency aid by both national governments and humanitarian organizations, but can also reduce response costs by over 50 per cent[427] and highlights that UNFPA has identified disaster preparedness as a 'vital component' within the UNFPA Strategic Plan 2014-2017, committing UNFPA to scaling up its programmes in humanitarian and fragile contexts 'to a significant extent'.[428]

425. UNFPA. Standard Operating Procedures for management of emergency surge deployments from UNFPA's global emergency roster. 2017
426. UNFPA. Guidance Note on Minimum Preparedness. 2016.
427. UNICEF/WFP. Return on Investment for Emergency Preparedness Study. 2014.
428. Ibid.

FIGURE 8: *UNFPA preparedness, DRR and resilience programming*



Source: UNICEF/WFP. Return on Investment for Emergency Preparedness Study. 2014.

The evidence from this evaluation indicates that UNFPA struggles to meet these commitments across leadership areas of SRHR, GBV and youth in all countries. This is, in part, due to the overall reluctance in releasing internal surge staff (who are necessarily those with existing humanitarian experience) which would serve to diffuse increased humanitarian knowledge and experience in a relatively organic manner across the organization. This reluctance is reported across UNFPA, from surge roster members who have been unable to deploy, from surge management and from requesting country offices.[429]

Key informants report that the UNFPA Deputy Executive Director has communicated internally on various occasions, reinforcing the fact that internal surge deployment is essential to an effective response in a rapid-onset emergency and the surge mechanism ultimately benefits all of UNFPA.[430] However, this has had limited impact on the internal surge mechanism (see findings under Evaluation Question 6 for more information).

Further, surge deployees report that the immediate burden of duties on external surge staff is so high that there is often limited time or space for these external surge deployees to transfer knowledge and skills to country office staff.[431] Country office informants reported that some highly experienced surge staff are able to do this in certain contexts, but this is the exception rather than the norm.[432]

However, a more fundamental issue is the organization-wide limitation with respect to humanitarian human resources, discussed above. This impacts negatively on preparedness, response and programming across the nexus. It then becomes a cyclical issue of struggling to build resilience into early recovery leading to limited preparedness leading to less effective response.

UNFPA has already recognized this gap and sought to mitigate the challenges through a roving global team of seven experts (already on the standby partner surge roster) funded by the Government of Denmark for three years starting in 2019. The team will prioritize WCARO, ASRO and ESARO, although providing support to LACRO, APRO and EECARO when necessary.[433] Many evaluation respondents noted their support for the concept of regional roving teams.[434]

There is recognition within UNFPA that, in the short to medium term, working to increase the knowledge and capacity of existing workforce is important and this must include allowing internal surge roster members to surge and benefit both the hosting country office and their own home country office when they return. Furthermore, many respondents highlighted the current absence of systematic training or learning opportunities, which include both institutionalized humanitarian training workshops such as those run in 2018 and highly praised across the organiza-

429. Multiple UNFPA key informants. For further information, refer to the thematic paper on human resources for humanitarian action and Annex V evaluation matrix EQ6A16 and EQ8A22 and EQ8A23.

430. UNFPA key informant.

431. Multiple UNFPA key informants. For further information, refer to the thematic paper on human resources for humanitarian action and Annex V evaluation matrix EQ6A16 and EQ8A22 and EQ8A23.

432. UNFPA headquarter key informants.

433. UNFPA regional key informants. For further information, refer to the thematic paper on human resources for humanitarian action.

434. Note that this becomes a similar argument to that of regional prepositioning of commodities, as outlined in the thematic papers on supply-chain management for humanitarian commodities and human resources for humanitarian action.

tion[435] and more innovative options suggested by respondents such as 'shadow-surging' for internal candidates with minimum experience but interest and commitment.[436]

UNFPA often works within the continuum frameworks of the wider humanitarian community and/or the host government, which can be positive. For example, the **Turkey** refugee response represents humanitarian action fully subsumed under the humanitarian-development continuum, as coordinated and led by the Government of Turkey. The planned integration of all WGSS into health centres and protection work with social service centres shows strong work toward long-term development goals.

However, this is not always the case in terms of refugee situations. In **Bangladesh**, respondents reported no conversation (as of late 2018) or plans vis-à-vis durable solutions for Rohingya refugees. Stakeholders reported concerns from the Government of Bangladesh in relation to planning for integration of refugees. This posed major questions with regard to the future of the Rohingya refugee community and indeed the host communities, in the longer term. UNFPA-supported doctors and midwives based at health facilities in the camps or at urban hospitals provide support to whoever needs it, thereby integrating services for refugees and host communities and contributing to a shared sense of purpose.[437]

The priority of an overarching continuum framework is not always the case in contexts of cyclical natural disasters. For example, in **Haiti**, the continuum approach, with preparedness at its centre, is critical but evidence demonstrates system-wide level failure to gain traction on building resilience. Responses to successive shocks remain, for the most part, reactive and repetitive.[438] Within this context, UNFPA is building resilience among service providers and increasing acceptance of facility-based services for SRH but with less success in relation to GBV. A perspective repeated by multiple stakeholders was articulated by one respondent as: "If there was another 2010 earthquake tomorrow, the results would be the same or worse than nine years ago: nothing has improved."[439]

In **Indonesia**, there is good evidence from internal and external stakeholders that UNFPA preparedness efforts link to its development programming for more effective and efficient humanitarian responses. UNFPA has integrated humanitarian response into all four outputs of the CPD 2016-2020 and undertakes monitoring of indicators linked to these outputs. It has also undertaken work to sensitize development staff to preparedness responsibilities and train them on MPAs and conducts an MPA coordination meeting twice per year. Further, UNFPA has a contingency plan that outlines components of a 'ready to deploy' programme, covering human resources, guidelines for mobilizing a response and programme priorities. The relevant MPAs are included in the personnel appraisal development (PADs) of various officers in the country office. UNFPA Indonesia reported planning for staff training on the ERF, CERF and FTP activation in 2019/2020.[440]

There is little evidence of overarching continuum frameworks in conflict contexts. In **Yemen**, a UNFPA stakeholder reported that, despite considerable attention to humanitarian programming, UNFPA Yemen is traditionally more attuned to longer-term development[441].UNFPA reported that, in 2019, the office would consider a new model of direct implementation of RH services in some facilities,[442] where service providers would be directly recruited and paid by UNFPA. This is because implementing partners reported being overwhelmed; a new model might be more cost-effective and controllable, despite limited evidence as to the sustainability of this model. Further, there was no evidence of strategies on early recovery or transition within the Yemen context. The HRP requirement increased from US$2.92 billion in 2018 to US$4.2 billion in 2019, a recognition of a deteriorating humanitarian situation, with no foreseeable end. UNFPA reports its partner strategy is to concentrate on providing life-saving services and plans for transition and early recovery and consider linking to development work at a later date.[443]

Further, there is little evidence that UNFPA successfully bridged the triple humanitarian-development-peace nexus. What evidence was identified indicates that UNFPA has struggled to systematically fulfil global obligations vis-à-vis UNSCR 2250 at the country level. UNSCR 2250 requested the Secretary-General of the United Nations "carry out a progress study on the youth's positive contribution to peace processes and conflict resolution, in order to recommend effective responses at local, national, regional and international levels." UNFPA and the peace-building support office jointly provided secretariat functions for the development of the study and therefore led in producing the study which is described as "an agenda-setting document, defining a strategy for the implementation of UNSCR

435. Multiple UNFPA key informants. For further information, refer to the thematic paper on human resources for humanitarian action and Annex V evaluation matrix EQ6A16 and EQ8A22 and EQ8A23.

436. Multiple UNFPA key informants. For further information, refer to the thematic paper on human resources for humanitarian action and Annex V evaluation matrix EQ6A16 and EQ8A22 and EQ8A23.

437. For further information, refer to Annex V evaluation matrix EQ8A22 and EQ8A23.

438. For further information, refer to the Haiti country note and Annex V evaluation matrix EQ8A22 and EQ8A23.

439. Haiti key informant.

440. Indonesia key informants. For further information, refer to the Indonesia country note and Annex V evaluation matrix EQ8A22 and EQ8A23.

441. Yemen key informant.

442. Yemen key informants. For further information, refer to Annex V evaluation matrix EQ8A22 and EQ8A23.

443. UNFPA key informants. For further information, refer to Annex V evaluation matrix EQ8A22 and EQ8A23.

2250."[444] However, little evidence has been identified by this evaluation of UNFPA leading or contributing to implementing this strategy for the implementation of UNSCR 2250 at country level.

UNFPA **Uganda** was highlighted by the 2018 *Meta-Analysis of the Engagement of UNFPA in Highly Vulnerable Contexts*[445] as a good example of a country office in strategic alignment of the triple nexus through the 2017 Uganda Comprehensive Refugee Response Framework and the integration of development, humanitarian and peace-building linkages as a programming principle[446]. However, respondents in Uganda reported a struggle to balance immediate needs of humanitarian resourcing (from UNFPA emergency funds and from CERF) and the Government of Uganda's insistence that all parties engaged in humanitarian assistance provide durable services and commodities. For example, in 2019, the Government of Uganda requested that UNFPA construct buildings and limit reliance on the use of semi-permanent structures or temporary shelters and also insisted on increasing the level of investment in the provision of skills-based services that are linked to vocational training or income generation.[447]

In May 2018, UNFPA **Somalia** launched a US$2million peace-building fund in coordination with the federal government and UN Habitat to facilitate youth political empowerment by enabling young Somali women and men to meaningfully engage in governance, peace-building and reconciliation efforts.[448]

In the **Philippines**, the new CPAP 2019-2023 under the 8th country programme explicitly aims to address the humanitarian/peace-building/development/human rights nexus in a systematic manner, by identifying concrete entry points. UNFPA reports recognition that working on a nexus approach will require, among others, the removal of silos; expansion of work to include resilience, recovery and DRR; integration of MISP in local and national DRR plans; back-up support of UNFPA for innovations at the development phase; and the completion of the common operational datasets as a tool for planning during emergencies. The CPAP explicitly aims to ensure continuity of these interventions post-disaster. In terms of operations, humanitarian-related work may be included for all staff, based on an agreed level of effort/percentage to ensure everyone's involvement in the humanitarian work of UNFPA.[449]

BOX 4: UKRAINE – TAKING ADVANTAGE OF A WINDOW OF OPPORTUNITY

НЕ БУЛО БИ ЩАСТЯ, ТА НЕЩАСТЯ ПОМОГЛО (SOMETHING GOOD OUT OF SOMETHING BAD)

Many evaluation respondents across Ukraine repeated this saying around how the conflict has opened the eyes of the Government and the public to GBV as a concept requiring attention.

Ukraine's law on Preventing and Combating Domestic Violence (#229-VIII) includes the right to comprehensive services for survivors, criminalizes perpetrators and updates Ukraine's commitment to UNSCR 1325. Its ratification in 2018 was partly due to advocacy from UNFPA and sub-cluster members.[453]

UNFPA has taken advantage of the window of opportunity opened by ratification of the law to focus on its implementation and promote an environment where GBV is recognized and more women and girls are willing and able to seek support services. The UNFPA GBV PSS mobile team model is integrated into the new GBV legislation and the Ministry of Social Policy intends to take over the UNFPA mobile teams and expand the programme across the country.

In addition to the PSS mobile team model, UNFPA supports a network of hotlines, SRHR service delivery points in state hospitals and safe spaces and shelters. These integrated response services are all considered as a model for national-level expansion and replication and could correct Ukraine's glaring deficiency of a standard basic package of GBV services. The fact that the GBV sub-cluster has been so inclusive of all actors – including attendance at meetings by police, health providers, social services, NGOs and women's groups – has ensured that the legislative package is also comprehensive. While there is still a long way to go – for example, GBV and domestic violence are still defined separately in law and in social norms – the GBV context in Ukraine is vastly different in 2019 than in 2014. This is largely due to the conflict and the UNFPA-led GBV response to this conflict[454] – something good out of something bad.

Information from Ukraine Country Note

444. Ibid.
445. UNFPA. Meta-Analysis of the Engagement of UNFPA in Highly Vulnerable contexts. 2018.
446. Ibid.
447. For further information, refer to Annex V evaluation matrix EQ8A22 and EQ8A23.
448. https://somalia.unfpa.org/en/news/somalia-launches-peace-building-fund
449. For further information, refer to Annex V evaluation matrix EQ8A22 and EQ8A23.

In **DRC**, UNFPA has undertaken some efforts that support connectedness of humanitarian response to peace and development progress despite significant contextual challenges. UNFPA has made important advances that link work with young people to the goal of creating a humanitarian-development-peace nexus. One example of such a project is called Tusikilizane, a collaboration between UNFPA, the United Nations Educational, Scientific and Cultural Organization (UNESCO) and the Food and Agriculture Organization (FAO) that promotes peaceful coexistence between the youth of two groups that are part of a violent inter-community conflict.[450] One respondent sees the project as helping to change the focus of UNFPA and its reputation within the humanitarian community:

UNFPA is thought to only work on sexual health. Its work on peace has changed the image of the agency among the population. It's an interesting approach – they want people to live in a stable situation. One thing to improve – peace requires more resources....UNFPA should give it more funding. Peace takes a long time. It's a long-term ambition. There are good ideas, but I'm afraid the funding is minimal.[451]

In **Nigeria**, UNFPA has partnered with the International Peace Institution for research to review gaps in the health system with a view to promoting social cohesion and peacebuilding.[452]

FINDINGS 30. There is significant evidence that UNFPA works closely with government as a national actor to build capacity for sustainability in humanitarian programming. At the same time, there is evidence in many of the countries examined for this evaluation that UNFPA works closely with local organizations for GBV work, particularly in the area of PSS, but without systematically targeting women's organizations.

As discussed above, evaluation evidence indicates that a notable strength of UNFPA across most, if not all, country contexts is the quality of partnerships with government at both national and sub-national/local levels.[455] Notwithstanding the previously discussed issues with the humanitarian principle of neutrality in contexts of conflict, this is generally a significant comparative advantage for UNFPA as a humanitarian response actor. There is clear evidence from across evaluation contexts of UNFPA building the capacity of government stakeholders as the primary national actors for humanitarian action.

In most countries included within the evaluation, the main UNFPA strategy is to ensure that GBV and SRH responses are integrated into existing state systems, where possible and appropriate and to provide support to those structures. For example, in **Yemen**, UNFPA has sought to focus the GBV and RH humanitarian response within existing state systems rather than parallel systems. This includes:

- Nationwide direct support for contraceptive commodities and emergency obstetric care (EmOC) direct to Ministry of Health facilities
- Continued support to rural midwives with performance-based payments
- Support to the Ministry of Health for the development of a costed RMNH strategy for both the humanitarian crisis and beyond
- Building capacities of service providers in concepts of gender and gender equality.

With respect to supply chain management, UNFPA is rebuilding local supply chains and sustainable health service infrastructure in Yemen through public and private partnerships.[456]

In **Uganda**, evidence also indicates how UNFPA works to establish response mechanisms within existing systems. This includes support to integration of RH and GBV prevention and response into disaster plans and responses via:

- Training staff within the national disaster management unit and Ministry of Health on integration of SRH, HIV prevention and GBV in disaster responses
- Training national trainers on the MISP for RH in emergencies as well as trained focal points in 13 regional referral hospitals on MISP
- Training district health teams of selected districts on advocating and implementation of MISP for reproductive health in emergencies.[457]

450. UNFPA DRC Annual report 2018, "Saving and Transforming Lives," p. 23.
451. DRC key informant.
452. UNFPA. Nigeria Humanitarian Nexus Road Map. 2018
453. Multiple Ukraine key informants. For further information, refer to the Ukraine country note and Annex V evaluation matrix EQ822 and EQA23.
454. Attitudes towards GBV across the world have changed since 2014, with the #metoo movement, for example. Therefore, it is not possible to claim the drastic change in Ukraine is solely due to the conflict and the UNFPA-led GBV response to the conflict. It is likely that the time was ripe for change to start to occur anyway; however, respondents to this evaluation overwhelmingly attributed the opening up of the conversation about GBV to the conflict and the response to that conflict. It seems clear that the humanitarian GBV response contributed significantly to the change 2014-2019.
455. For further information, refer to EQ2 finding 7 and EQ4 finding 16 in this report and Annex V evaluation matrix EQ2A4 and EQ4A12.
456. For further information, refer to Annex V evaluation matrix EQ8A24.
457. UNFPA. Uganda's Humanitarian-Development Nexus Approach. 2017.

UNFPA **Uganda** also aligns its humanitarian work with government-led emergency task force activities including meetings and inter-agency joint needs assessments set up to respond to specific disasters.[458]

In **South Sudan**, UNFPA has reported extensive capacity-building support to the Ministry of Health and programs to train health professionals. However, some evaluation respondents noted a constraint on activities included in the interim cooperation framework due to poor political participation, weak systems and low levels of education.[459] UNFPA South Sudan continues to support a project to deploy midwives across South Sudan's ten states to deliver clean delivery, dignity kits and comprehensive emergency obstetric care[460] that includes partnering with the Ministry of Health to scale up midwife education, increase capacity for delivery of emergency obstetric care and improve clinical practice for midwifery, nursing, associate clinicians and medical students.[461]

In **Nigeria**, UNFPA also reported seeking to embed GBV and RH humanitarian response within existing federal and state systems rather than establishing parallel systems.[462] This includes:

- Programme components that are well aligned to country/local government area needs, national and international agenda and frameworks
- Nationwide support for commodities and health infrastructure/training development
- Efforts to build capacity of health care workers and midwives
- Strengthening the national health management Information system through printing data collection tools and distribution to health facilities
- Establishment of a platform for religious and traditional leaders on RH/family planning.[463]

Across the different country contexts, UNFPA implements a considerable proportion of its work via national implementing partners. There is evidence of dedicated efforts within humanitarian programming to build the capacity of local CSOs to meet UNFPA project management standards.

The Grand Bargain confirmed a commitment from the largest humanitarian donors and aid organizations to make sure national and local partners are involved in decision-making processes in any humanitarian response and deliver assistance in accordance with humanitarian principles. Under the localization work stream, six commitments were agreed:

1. A multi-year investment in the institutional capacities of local and national responders
2. The removal of barriers that prevent organizations and donors from partnering with local and national responders
3. Support for national coordination mechanisms
4. A target of at least 25 per cent of humanitarian funding to local and national responders
5. Setting a 'localization' marker to measure direct and indirect funding to local and national responders
6. Greater use of funding tools to increase/improve assistance by local and national responders.[464]

Despite good performance in national partner funding (discussed above), no stakeholders at country level expressed awareness of a corporate UNFPA policy to implement the localization agenda nor of any specific strategy for partner choice to assist country operations in humanitarian response. Some country offices noted including strategies that align with the localization agenda but not via explicit recognition of the Grand Bargain commitment by the country office.

Where localization is an explicit goal based on the Grand Bargain localization commitment, it is generally articulated through a GBV sub-cluster strategy influenced both by UNFPA leadership and by UNHCR leadership of the protection cluster (under which the GBV sub-cluster sits) and HCT-dictated areas of prioritization. For example, in **Yemen**, the 2016 GBV sub-cluster strategy included plans to reach out to local partners "that possess unique outreach capacities (e.g., women's groups)."[465] UNFPA has a key strategic partnership with Yemen Women's Union which works across the country, has the confidence of communities on both sides of the conflict and is considered a potential GBV sub-cluster co-lead.[466]

458. Ibid.
459. South Sudan key informants. For further information, refer to Annex V evaluation matrix EQ8A24.
460. https://reliefweb.int/report/south-sudan/south-sudan-camp-midwifery-training-offers-crucial-lifeline
461. Ministry of Health. Gender Training Manual for Gender Mainstreaming Checklist for Health Sector in South Sudan, 2017.
462. For further information, refer to Annex V evaluation matrix EQ8A24.
463. Ibid.
464. OCHA. Localization. https://www.unocha.org/lebanon/localization
465. OCHA. Humanitarian Response Plan. 2016.
466. In April 2019, Yemen country office reported that the Yemen Women's Union were being considered as a potential GBV sub-cluster co-lead. In August 2019, the GBV AoR report that the Yemen Women's Union is now the col-lead of the GBV sub-cluster in Yemen and Yemen is the only country to have a national organization (which is not a government ministry) as the GBV sub-cluster co-lead.

In some contexts, UNFPA has a clear strategy of working with CSOs. For example, in **Haiti**, UNFPA partners with two youth CSOs. However, in other contexts, there was no evidence of a specific strategy to engage with women or youth CSOs. In **Indonesia**, women's CSOs, in particular, have not been substantially targeted as part of a long-term strategy to improve GBV prevention and response capacity in the country.[467]

In **Somalia**, the current UNFPA strategy is to work closely with government and gradually over the years reduce support for specific facilities as line ministries take up direct management and funding of the services, permitting UNFPA to attend to emerging needs. There is limited information about strategic partnerships with CSOs, or specific targeting of women or youth organizations.[468]

In **Chad**, programme activities are implemented in collaboration with governmental partners, including the Ministry of Health through a direct payment process to the Government for all payments related to services and procurement of goods.[469] There is no information with regard to a strategy for working with civil society.

In the **Philippines**, all policies and programmes of UNFPA with regard to SRHR humanitarian response are embedded within relevant government agencies mandated to respond in a humanitarian crisis.[470] In Colombia, UNFPA reports that the Government is the primary partner for all items in the results framework of the country plan, with limited information vis-à-vis working with civil society women and youth organizations.[471]

Therefore, while partnership with government is a constant and visible strategy across all UNFPA humanitarian responses, partnerships with women and youth CSOs are more ad hoc and less strategic and consistent.[472]

467. For further information, refer to the Indonesia country note and Annex V evaluation matrix EQ8A24.

468. For further information, refer to Annex V evaluation matrix EQ8A24.

469. UNFPA, Office of Audit and Investigation Services. Audit of the UNFPA Country Office in Chad, Final Report No. IA/2016-08. 2016.

470. Philippines key informants.

471. Colombia key informants.

472. The GBV AoR has a localization task team and has been working closely with the Child Protection AoR on the localization in coordination agenda. There are three regional workshops planned with GBV Coordinators and women-led organizations together with government partners in the latter half of 2019. The aim is to increase meaningful engagement in the GBV Sub-Clusters and the GBV AoR Core Membership – UNFPA GBV AoR key informant.

(c) UNFPA Yemen, Expanding the Al Thawra hospital in Yemen

4 CONCLUSIONS

CONCLUSION 1: UNFPA demonstrated a significant trend of progress in performance across many aspects of humanitarian action between 2012 and 2019. This has been strategic in terms of alignment with the mandate of UNFPA (specifically SRHR and GBV), as articulated by both the 2012 second-generation humanitarian strategy and successive strategic plans. There is a clear consensus from evaluation respondents across country, regional and global levels, both internally and externally, that UNFPA humanitarian capacity has significantly improved over the last decade.

In 2015 (the earliest year for which full data was available) the global UNFPA humanitarian spend was US$82,386,133. In 2018 it was US$172,625,466 which accounts for 31 per cent of total spend for that year, a near doubling of humanitarian activity in financial terms in just three years. This growth exists within the overall context of a scaling up in international response to meet increasing humanitarian needs but is also indicative of the evolution in scale of humanitarian action within UNFPA.

As a result, UNFPA and its mandate have gained increased visibility within the humanitarian sphere. This has included:

- UNFPA assuming specific IASC-designated responsibilities, such as leadership of the GBV Area of Responsibility
- UNFPA ensuring the integration of mandate-designated responsibilities such as:
  - Increasing awareness of MISP for reproductive health in crises
  - Providing and supporting life-saving services for women and girls
  - Providing emergency reproductive health kits and supplies to local partners to enable service delivery.

Links to findings 1, 3, 8

CONCLUSION 2: In the last decade, UNFPA has progressively mainstreamed humanitarian assistance in all its strategies and programmes, with a marked shift since the adoption of the UNFPA Strategic Plan 2014-2017. Globally, UNFPA significantly increased its humanitarian function in 2019 by upgrading the Humanitarian and Fragile Contexts Branch to a Humanitarian Office. Similarly, UNFPA increased its surge capacity by adding to its initial internal roster an external roster as well as standby partnerships.

However, this evolution has not been uniform throughout UNFPA systems, policies and procedures and the overarching institutional approach remains predominantly development-orientated, which presents disadvantages in humanitarian action.

This manifests in different areas such as:

- **Finance:** a low appetite for financial risk at the expense of speed. While this is effective for development response, it hampers effective humanitarian response, for which being fast is as important as meeting good – not the highest attainable – quality standards
- **Human Resources:** an over-utilization of surge due to the inequality in experience and capacity between UNFPA surge and roving teams and the humanitarian capacity in general staffing. This is a major concern for country offices facing protracted crises where long-term human resources are required
- **Supply chain management:** long ordering processes and stock control mechanisms designed for development timelines rather than humanitarian timelines.[473] A paradigm shift in thinking is required within UNFPA senior management to adopt a more humanitarian-related risk appetite and then to ensure policies and procedures flow from this.

Links to findings 21, 23

473. For further information, refer to the thematic paper on supply-chain management for humanitarian commodities.

CONCLUSION 3: The second-generation humanitarian strategy was relevant to UNFPA in 2012 and it has set the foundation for the mainstreaming of humanitarian action in subsequent strategic documents. However, due to the changing global humanitarian context and the UNFPA role within humanitarian action, the strategy requires updating.

The changing context includes:

- Increased humanitarian needs
- An increasing understanding across all humanitarian actors of SRHR and GBV responses as life-saving humanitarian interventions (a recognition credited at least in part to UNFPA) and consequently the UNFPA responsibility within these areas
- The NWoW under the Agenda for Humanity emanating from the 2016 World Humanitarian Summit.

UNFPA is facing global challenges and developments in the global humanitarian response architecture that the 2012 strategy did not anticipate. Humanitarian outcomes have been integrated into subsequent strategic plans to adjust to these changes. However, more is required to position humanitarian preparedness, response and recovery within the UNFPA organizational culture and ensure that UNFPA can keep pace with the ongoing changes in humanitarian crises and the global humanitarian architecture.

Links to findings 3, 5, 13

CONCLUSION 4: UNFPA has put in place several useful monitoring systems. However, the lack of coherent and comprehensive monitoring data means it is not possible to fully measure the effectiveness of UNFPA humanitarian action. This includes:

- Data currently collected is primarily at the activity level (such as number of personnel trained on MISP, for example) mixed with output level (such as number of antenatal care visits recorded)
- Data is recorded against inconsistent timeframes within country responses and across UNFPA, which does not allow for easy consolidation of annual results and contributes to weak overall monitoring of results at the global level
- Data is presented in datasets that do not systematically demonstrate either output- or outcome-level results (such as women and girls accessing services through a service delivery point equipped with post-rape kits)
- Data is often not specified (nor is consistent across countries) as individuals or services (i.e., one woman receiving a series of antenatal, safe delivery or post-natal care services, compared to each service being counted)
- The absence of common, consistently articulated and consistently understood targets.

The current data situation makes it very difficult to determine the effects of UNFPA-supported interventions at both coverage level and at quality level which includes whether UNFPA humanitarian action is consistently meeting internal and external quality standards.

Links to findings 11, 12, 14, 15

CONCLUSION 5: There are many examples of processes being successfully applied across humanitarian and fragile settings for needs assessment, geographical targeting, demographic targeting. This evaluation noted strong evidence that regular and continuous assessment of needs are conducted and that responses are being adjusted in response to the identified needs. Across the sample of countries examined for this evaluation, there is evidence of an evolution of humanitarian response across different phases of a crisis, adapting to changing needs of affected populations. These leverage the UNFPA approach to work effectively across the humanitarian-development nexus and working with women and youth civil society. However, there is no systematic approach to these processes and often UNFPA staff struggle to access adequate corporate guidance. This results in missed opportunities for synergy and, at times, duplication of effort in developing/implementing basic approaches, tools and processes. Examples include (a) limited corporate guidance for needs assessments, although encouraged for accessing emergency funds and for CERF (either agency-specific, or joint assessments); (b) when or how to adapt programming – particularly within the context of moving from an immediate response 'coverage' priority to a medium-term response increasing "highest possible quality" priority, to a longer-term response across the double (humanitarian-development) and triple (humanitarian-development-peace) nexuses; and (c) standardized mechanisms for AAP and PSEA.

Links to findings 1, 9, 10, 18, 29, 30

CONCLUSION 6: While it has become more difficult for UNFPA to mobilize core resources to deliver its mandate at the global level, UNFPA has been increasingly successful in mobilizing other humanitarian resources at country level, such as pooled funds. Within this funding context, the main issue for UNFPA consists in setting priorities for the allocation of UNFPA humanitarian funds across mandate areas.

Links to findings 20, 23

CONCLUSION 7: UNFPA has some good practices in terms of the delivery of IARH kits at the beginning of an emergency. However, UNFPA is also perceived as being slow and not always matching other agencies in this regard, although there are regional variations. Currently, the supply chain model operated by UNFPA is not optimal or specific for humanitarian response. Before systems can change, UNFPA must acknowledge it is not possible to be an effective humanitarian supplies agency without taking a higher level of risk with the aim of ensuring timely delivery and set/adjust to a new norm in this regard.

Links to findings 23

CONCLUSION 8: While there are highly knowledgeable humanitarian experts in the organization, they are too few in number in view of the scope of UNFPA humanitarian accountabilities. Humanitarian capacity in terms of quantity of specialized staff and the quality of expertise among all staff is not sufficient to optimally deliver on mandate and commitments within humanitarian action. Often there is limited humanitarian knowledge, expertise and understanding across general staffing capacity and particularly at senior levels in many country offices. This is most clearly exemplified by frequent lack of understanding of the humanitarian architecture, the operational flexibility provided by FTPs, the cluster system, what it means to be a cluster lead agency, pooled funding mechanisms, PSEA (notably the differences between PSEA and GBV) and humanitarian principles. Being able to fluently maneuver (position and leverage) within the modern humanitarian architecture at country levels would enhance the advancement of UNFPA capabilities as a major humanitarian actor.

Links to findings 17, 21

CONCLUSION 9: Inclusion analysis is integrated within UNFPA humanitarian programming but has not evolved to a sophisticated level that is fully aligned with the principle of leaving no one behind. In particular, in response to specific dimensions of inclusion:

- **Women and girls:** While UNFPA-mandated areas of programming (SRHR and GBV) lend themselves to gendered understanding of vulnerability, further disaggregated analysis is required to identify and reach specific groups of vulnerable women and girls effectively
- **Adolescents and youth:** UNFPA has successfully increased focus on adolescents and youth within its programmes
- **Persons with disability:** While all country offices included within this evaluation recognized the need to ensure inclusion of people with disabilities, there was limited evidence that programming at country level is achieving this.
- **LGBT+ populations:** There is almost no inclusion of humanitarian action to reach LGBT+ populations, which should be a key part of UNFPA programming within the mandate and global commitment of UNFPA in line with the global stance of UNFPA on these groups.

Links to findings 4, 19

CONCLUSION 10: UNFPA has improved accountability to affected populations and protection from sexual exploitation and abuse frameworks. However, it still does not adequately address AAP and PSEA at all levels.

- For AAP, knowledge – both as a concept and more practically (i.e., how to establish feedback mechanisms) – is inconsistent across countries, with limited guidance from headquarters on global best practice for this although there are ongoing efforts to improve AAP
- For PSEA, UNFPA has significantly increased the level of corporate guidance on UNFPA responsibilities for PSEA for UNFPA staff, programmes and partners, but this has yet to manifest in a tangible manner across country-level implementation, where PSEA expertise within UNFPA remains basic.

Links to findings 9, 10

CONCLUSION 11: UNFPA has a demonstrated and laudable record of close relationships with government partners within development contexts and this has represented a clear comparative advantage for humanitarian action. This includes positioning UNFPA very well within the current humanitarian direction of the NWoW and working toward collective outcomes across the humanitarian-development-peace nexus. There is no extant global strategy to fully leverage this position to its best advantage. However, in addition to this clear comparative advantage, working closely with governments in some contexts (such as conflict contexts where government may be a non-neutral party to the conflict) presents a risk vis-à-vis humanitarian principles of neutrality, impartiality and independence. Management of this risk requires a full and comprehensive understanding of humanitarian principles across all levels within a country operation.

Links to findings 6, 7, 16, 29, 30

CONCLUSION 12: UNFPA is committed to prioritizing the localization agenda as introduced in the Grand Bargain commitments and improvements have been made on this between the adoption of the Grand Bargain following the World Humanitarian Summit in 2016 and 2018. However, UNFPA has yet to develop a global strategy to ensure localization of aid, targeting specifically grassroots women's organizations and youth organizations within humanitarian response.

Links to findings 24, 30

CONCLUSION 13: UNFPA leadership and coordination role across IASC and mandated areas have significantly improved in recent years. The GBV Area of Responsibility, the global level forum for coordination and collaboration under the humanitarian cluster approach on GBV prevention and response, has progressed positively since UNFPA assumed sole leadership in 2017. In 2019 it has been adequately resourced for the first time, albeit not wholly based on core resource commitment from UNFPA. Evidence from GBV practitioners and others engaged in humanitarian programming indicates that the AoR has progressed positively since 2016, when UNFPA began assuming sole responsibility for its leadership. However, UNFPA still faces key challenges to effectively and consistently deliver on these leadership commitments.

- While the coordination of the IASC-formalized GBV AoR has improved across the period of this evaluation, UNFPA still lacks capacity to fully deliver on its long-term commitment as a cluster lead agency. Many GBV sub-clusters at country level are under-resourced in terms of both human resources and financial resources

- For SRHR, there is clear evidence of reproductive health working groups at the country level having a positive impact on health programming. UNFPA leadership of informal RH working groups under the IASC WHO-led Health Cluster are effective and useful. However, in crises where SRHR working groups are not present, SHRH is deprioritized, particularly for those elements of SRHR beyond MNH

- The absence of UNFPA coordination leadership for youth at the country level prevents UNFPA from meeting global commitments assumed with the Compact for Young People in Humanitarian Action and UNSCR 2250

- The role of UNFPA as the United Nations entity for population and the associated expertise in development settings has not been leveraged sufficiently for humanitarian action across all actors.

Links to findings 25, 26, 27, 28

(c) J. Ward, 2019, Internally displaced persons hut, DRC

5 RECOMMENDATIONS

STRATEGIC RECOMMENDATION 1:
UNFPA should develop a strategic framework for humanitarian action.

Suggested actions: This strategic framework should address the following elements:

- Changes in the external environment and within global humanitarian architecture structures since the previous UNFPA humanitarian strategy in 2012
- A stronger UNFPA role within this architecture
- Highlighting the focus for UNFPA of working across and bringing together, the constituent parts of the triple nexus.

This framework should be embodied in a standalone document, additional to (but, crucially, not replacing) the integration of humanitarian response within the 2018-2021 Strategic Plan and should be built upon the existing humanitarian vision paper. This framework would serve four fundamental purposes, being:

- Positioning and emphasizing UNFPA within the humanitarian system
- Supporting accountability
- Focusing efforts and resourcing across the mandate areas of UNFPA
- Guiding future resource mobilization.

The framework should also include an identified level of internal funding through revolving or bridging funding mechanisms necessary to ensure UNFPA capacities to respond in a timely manner to all emergencies and, working backward from this figure, develop a long-term resource mobilization strategy aspiring to this identified resource requirement.

In addition to this framework, UNFPA should continue with the integration of humanitarian action within successive UNFPA strategic plans.

Links to conclusions: 1, 2, 3
Targeted at: Humanitarian Office and senior management
Priority level: HIGH

OPERATIONAL RECOMMENDATION 2:
UNFPA should review existing datasets and monitoring systems to identify current gaps and bottlenecks and use this to develop a comprehensive data management system.

Suggested actions: This should be integrated into the new ERP platform and should focus on both data management at indicator level and data collection systems. Elements of the data management must include:

- Distinguishing output and outcome levels as related to humanitarian datasets used within Humanitarian Response Plans, but also for UNFPA core mandate areas and links results-monitoring across short term (humanitarian), medium term (higher-level output and some outcome indicators) and longer term (linking results management across the humanitarian-development nexus)
- Distinguishing different purposes of data use (such as for targeting, programming, advocacy, communications and resource mobilization)
- Strengthening the collection of quality data against the global mandatory indicators to ensure comparability and consolidation.

Links to conclusion: 4
Targeted at: Policy and Strategy Division and Humanitarian Office
Priority level: HIGH

OPERATIONAL RECOMMENDATION 3:
The UNFPA knowledge management approach should include a work plan to ensure ongoing embedding of corporate guidance on humanitarian processes at field level.

Suggested action: This should closely link within the Enterprise Resources Platform (ERP) currently being developed and the Policies and Procedures Manual document repository in use, but bottlenecks should be identified for specific humanitarian issues as to whether guidance does not exist; guidance exists but is not accessible to countries (through lack of knowing how to navigate the system or through over-abundance of guidance); or guidance exists and is accessible but is not useful for the intended purpose. This recommendation must be implemented in line with the HR recommendation (see recommendation 5) and specific elements should include:

- Mapping existing guidance and identifying gaps
- Rationalizing the guidance to ensure country offices at the beginning of a crisis are aware of the most relevant guidance to use
- Developing a workplan for prioritization of new guidance based on field-level demand
- Communicating availability and rolling-out existing guidance to country offices at regular intervals

Links to conclusions: 5, 11, 12
Targeted at: Policy and Strategy Division and Humanitarian Office
Priority level: LOW

OPERATIONAL RECOMMENDATION 4:
UNFPA should review the corporate approach on preparedness for supplies, including where necessary regional stockpiling and national pre-positioning.

Suggested actions: As part of this process, an organization-wide preparedness policy, including regional stockpiling and national pre-positioning, should be developed that considers differentiating between contexts, commodities and integrating learning from ongoing initiatives. With this, a new corporate approach for regional stockpiling and national pre-positioning should be based on the fundamental concept of speed being as critical a factor in humanitarian response as cost and quality. The new approach should also include a review of human resources for humanitarian logistics and monitoring of commodities so UNFPA can continually monitor delivery times and availability of supplies in line with the best-practice supply chain management in a more consistent and robust manner.

Links to conclusions: 2, 7
Targeted at: Humanitarian Office, Procurement Services Branch, Division of Management Services, senior management
Priority level: HIGH

OPERATIONAL RECOMMENDATION 5:
UNFPA should develop a comprehensive plan for increasing humanitarian expertise.

Suggested actions: UNFPA should develop a long-term (five-year) humanitarian human resources strategy for increasing general (non-surge) humanitarian expertise within the agency and allocate the necessary budget for it. This should be based on a clear pre-baseline (from 2012), a current baseline (2019) and an ambitious but realistic (based on a global capacity assessment) goal (2025). The strategy should include a clear three-pronged approach including:

- **New personnel:** Ensure significant humanitarian expertise is required in all (relevant) job profiles for incoming staff by:

  a. Inserting humanitarian requirements into relevant job profiles, including senior management

  b. Developing humanitarian test materials for relevant job interview processes

  c. Systematically ensuring humanitarian colleagues with requisite experience and expertise are included in all interview panels

- **Existing personnel:**

  a. Fund a continuation of the regional humanitarian capacity-building workshops training initiative which started in 2018 on an ongoing basis

  b. Launch an organization-wide, country-level humanitarian workshop training initiative, focusing on the countries which are most at risk according to the INFORM index

  c. Develop a specific senior-level intense training/awareness-raising/support plan targeted at different experience/skill cohorts, i.e., those with robust humanitarian experience; those with limited such experience but interest; those with minimal relevant experience. Consider a mentoring programme, linking those within the first cohort to those within the third cohort

  d. Pilot a 'shadow-surge' roster for those in lower-level positions who have limited experience but high interest in learning, to gain exposure in protracted crises

  e. Systematically utilize surge/roster deployees to transfer skills when appropriate, for example:

     i. First-wave personnel (surge or roving team) staff transferring humanitarian skills where and if possible (noting that humanitarian response remains at the core function of the deployment)

     ii. Second-wave personnel (surge or contracted) staff consistently being required to transfer skills

     iii. Longer-term or later deployed humanitarian personnel having a core responsibility within their ToR to transfer humanitarian skills

This should complement UNFPA efforts to sensitize all country management on the purpose of surge and the support required for surge deployees via a systematic process of training.

- **DHR staff:** Build a core team with responsibility for humanitarian staff to ensure speed, consistency, quality and follow-up (including return) of humanitarian personnel identification, recruitment and deployment.

Links to conclusion: 8
Targeted at: Humanitarian Office, Division of Human Resources
Priority level: HIGH

PROGRAMMATIC RECOMMENDATION 6:
UNFPA should develop an inclusion strategy that is based on leave no one behind but goes further to incorporate reaching the furthest behind first.

Suggested actions: This should be developed from the current corporate guidance on inclusion, which references humanitarian once (the August 2019 draft which states UNFPA "will address inequity in access to, the poor quality of and the lack of social accountability for sexual and reproductive health services in all contexts, including humanitarian and fragile contexts and in public health emergencies") but provides no concrete or tangible guidance for how to do this in humanitarian settings).

The following elements must be included within a document that provides pragmatic and practical guidance on how to ensure inclusion within humanitarian settings (rather than stating that inclusion must be ensured):

- All those who are geographically hard to reach because of conflict lines, insecurity, or inaccessibility caused by natural hazards
- **Women and girls:** how to ensure greater disaggregated analysis, providing understanding of the differentiated vulnerabilities of specific groups of women and girls (such as widows, divorcees or younger adolescents). UNFPA could build on the work undertaken by the Whole of Syria GBV sub-cluster to develop global guidance
- **Adolescents and youth:** UNFPA should develop a plan to roll out the new guidelines for young people in humanitarian action when the guidelines are launched (planned 2019)
- **Persons with disabilities:** UNFPA should develop a plan to roll out new guidelines for inclusion of persons with disabilities in humanitarian action when the guidelines are launched (planned 2019)
- **LGBT+ populations:** UNFPA should develop a position paper clearly stating responsibilities within the global humanitarian architecture vis-à-vis LGBT+ populations.

Links to conclusion: 9
Targeted at: Humanitarian Office, Policy and Strategy Division
Priority level: LOW

PROGRAMMATIC RECOMMENDATION 7:
UNFPA should undertake a mapping of existing AAP initiatives at country level with a view to incorporating good or promising practice guidance.

Suggested actions: Based on identified good or promising practices on AAP, UNFPA should develop humanitarian-specific (taking into account unique challenges of displaced, conflict and hard-to-reach populations) pragmatic guidance on how best to establish sustainable feedback channels accessible by all vulnerable persons and systematic mechanisms for incorporating feedback into the programming cycle.

Links to conclusion: 10
Targeted at: Humanitarian Office, regional offices
Priority level: LOW

PROGRAMMATIC RECOMMENDATION 8:
UNFPA should conduct a survey of PSEA knowledge and capacity at country level to establish the current bottlenecks between global level and country level.

Suggested actions: This should be used as a basis to identify where UNFPA remains at highest risk regarding sexual exploitation and abuse and develop a resourced workplan to systematically reduce this risk at the field level, where day-to-day contact with vulnerable women and girls within communities (by both UNFPA and partner staff) represents the highest risk.

Links to conclusion: 10
Targeted at: Humanitarian Office, regional offices, PSEA Coordinator
Priority level: HIGH

PROGRAMMATIC RECOMMENDATION 9:
UNFPA should develop a UNFPA-supported resourcing plan for ensuring GBV sub-clusters are resourced equivalently to other clusters with well-capacitated coordinators.

Suggested actions: UNFPA should ensure that the UNFPA GBV minimum standards are adhered to, which includes a dedicated GBV sub-cluster coordinator but, further than this, UNFPA should address the ongoing issues of:

- High turnover of coordinators deployed through the surge mechanism resulting in reduced functionality of sub-clusters
- Continued double/triple-hatting coordinator positions in sub-clusters[474]
- Lack of information management functions within GBV sub-clusters

This resource plan must include UNFPA GBV programming and technical expertise at the field level to ensure strong leadership in addition to its coordination role.

Links to conclusion: 13
Targeted at: Humanitarian Office
Priority level: MEDIUM

PROGRAMMATIC RECOMMENDATION 10:
UNFPA should develop a plan to further systematize the establishment and functioning of RH working groups.

Suggested actions: This should be done without formalizing RH working groups under the IASC cluster system and should include:

- The establishment of a mechanism to monitor how many L3, L2 and L1 crises (where cluster systems have been activated) have a functioning RH working group led by UNFPA[475]
- A review of current emergencies without RH working groups and a light-touch survey/assessment of the impact of not having RH working groups established and recognized as an informal platform within the overall cluster system/refugee response system
- A mechanism to systematically collect the achievements and added value of RH working groups, to be collated and used for advocacy purposes to ensure that RH working groups are considered a valuable addition in all crises.

Links to conclusion: 13
Targeted at: Humanitarian Office
Priority level: MEDIUM

474. Note that, as per cluster coordination guidelines and UNFPA own minimum standards, GBV sub-clusters should have a dedicated cluster coordinator (rather than a staff member undertaking both a UNFPA programming role and the cluster coordination role).

475. Note that official terminology of "IASC humanitarian system-wide scale-up protocols" has, since November 2018, replaced the previous "IASC humanitarian system-wide emergency activation (L3 response)" terminology. https://interagencystandingcommittee.org/iasc-transformative-agenda/content/iasc-humanitarian-system-wide-scale-protocols-released However, L1,2,3 terminology is still widely used within the humanitarian sector including within UN agencies and IASC definitions of crisis.

PROGRAMMATIC RECOMMENDATION 11:
UNFPA should review the gap between global-level leadership in the areas of humanitarian response and peace and country-level tangible action and develop a resourced plan to bridge this gap.

This plan should include:

For young people in humanitarian action:

- A survey of L3, L2 and L1 crises and where UNFPA leads a functioning coordination mechanism for young people in action and where gaps remain
- An assessment of resources required to ensure that the UNFPA global-level commitment is translated into tangible country-level action
- A review of potential partners to cover the country-level gaps identified from the survey

For the youth and peace agenda:

- A review of country-level UNFPA-led initiatives and a mapping of non-UNFPA initiatives
- An assessment of resources required to ensure that the UNFPA global-level commitment is translated into tangible action
- A mapping of partners (for resources and collaboration) on youth in peace
- A clear position statement for youth and peace outlining what UNFPA commits to do in terms of tangible, country-level action over the next five years, including identifying where gaps remain and where partnerships must be considered.

Links to conclusion: 13
Targeted at: Humanitarian Office
Priority level: MEDIUM

PROGRAMMATIC RECOMMENDATION 12:
UNFPA should review the activities referenced within the 2018 Letter of Understanding with OCHA as a foundation for increasing the UNFPA data footprint within humanitarian action.

UNFPA should subsequently develop a humanitarian data vision paper which:

- Establishes the medium-term (three-to-five years) vision of the position and responsibility UNFPA wants to have vis-à-vis humanitarian population, health and gender data at global, field and country levels
- Details the resourcing (platforms, staffing and funding) realistically required for this
- Develops a workplan, including a resource mobilization plan to deliver the vision, including the activities outlined in the 2018 LOU

Links to conclusion: 13
Targeted at: Humanitarian Office
Priority level: MEDIUM

Ensuring rights and choices for all

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