META-ANALYSIS OF THE ENGAGEMENT OF UNFPA IN HIGHLY VULNERABLE CONTEXTS

UNFPA Evaluation Office
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Meta-analysis of the engagement of UNFPA in highly vulnerable contexts

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ABBREVIATIONS AND ACRONYMS

APRO	UNFPA Asia and Pacific Regional Office
ASRO	UNFPA Arab States Regional Office
CCPE	Clustered Country Programme Evaluation
CERF	United Nations Central Emergency Response Fund
CPD	UNFPA Country Programme Document
CPE	UNFPA Country Programme Evaluation
CPAP	UNFPA Country Programme Action Plan
DHS	Demographic Health Survey
DRC	Democratic Republic of the Congo
DTM	International Organization for Migration's Displacement Tracking Matrix
EECARO	UNFPA Eastern Europe and Central Asia Regional Office
ESARO	UNFPA East and Southern Africa Regional Office
EQ	Evaluation Question
FTPs	Fast-Track Procedures
GBV	Gender-Based Violence
GBViE	Gender-Based Violence in Emergencies
GBVIMS	Gender-Based Violence Information Management System
HCT	Humanitarian Country Team
HFCB	UNFPA Humanitarian and Fragile Context Branch
HMIS	Health Management and Information System
HRR	UNFPA Humanitarian Response Reserve
HQ	UNFPA Headquarters
IASC	Inter-Agency Standing Committee
INFORM	Index for Risk Management
IPPF	International Planned Parenthood Federation
IOM	International Organization for Migration
IRRF	UNFPA Integrated Results and Resources Framework
LACRO	UNFPA Latin America and Caribbean Regional Office
M&E	Monitoring and Evaluation
MIRA	Multi-Cluster/Sector Initial Rapid Assessment
MISP	Minimal Initial Service Package for Reproductive Health in Emergencies
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OEE	Organizational Effectiveness and Efficiency
PDNA	Post-Disaster Needs Assessment
PSB	UNFPA Procurement and Supply Branch
RAS	UNFPA Resource Allocation System
RH	Reproductive Health
RO	UNFPA Regional Office
RR	Reproductive Rights
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
SP	UNFPA Strategic Plan
UNDG	United Nations Development Group
WCARO	UNFPA West and Central Africa Regional Office
WFP	World Food Programme

FOREWORD

A highly vulnerable context is when a country is at a high risk of experiencing a humanitarian crisis or is facing, or emerging from, a humanitarian situation such as a natural disaster, epidemic or armed conflict. UNFPA is increasingly engaging with countries such as these and so the UNFPA Evaluation Office has conducted this meta-analysis to generate cross-country learning on the contribution of UNFPA to emergency preparedness and response and to build resilience within the organization.

The meta-analysis built upon the results of six previously completed country programme evaluations covering Bangladesh, the Democratic Republic of the Congo, Haiti, Liberia, Myanmar and Nepal. It further gathered information on a wider circle of 25 UNFPA priority humanitarian countries. The meta-analysis covered the period 2012-2016, with emphasis on the period of the UNFPA Strategic Plan 2014-2017.

Among the findings and conclusions of the meta-analysis, four key messages were identified. These key messages should inform future programming in highly vulnerable contexts.

The first message the meta-analysis concluded was that a fair basis has already been laid for UNFPA to position itself strategically and programmatically within the humanitarian-development nexus, although a corporate vision is needed. UNFPA should therefore develop a strong corporate strategy on working across the humanitarian-development-peace nexus.

The second key message from the meta-analysis is that, while UNFPA has clearly emerged as a humanitarian agency, funding is not commensurate with population needs and corporate commitments. UNFPA should use the mid-term review of the UNFPA Strategic Plan 2018-2021 to improve the UNFPA resource allocation system. This would enhance the capability of country offices to adequately finance their emergency and response plans and leverage additional resources. A stronger focus on preparedness should also be placed in UNFPA country programmes to manage humanitarian needs.

The third key message highlighted 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. UNFPA should therefore review its office structuring to meet strategic plan humanitarian requirements. The meta-analysis also suggested ensuring that there was an adequate presence of dedicated humanitarian staff in UNFPA priority humanitarian countries.

The fourth key message contained in the report was that UNFPA is at a crossroads whether to invest in becoming a go-to agency for humanitarian data or to accept a more modest role. The meta-analysis suggested clarifying expectations underlying “increasing investment in data in emergencies” as per the UNFPA Strategic Plan 2018-2021. Such a clarification is necessary to ensure the availability of adequate expert support for country offices at headquarters and regional offices and to explore options for better using and integrating population and development officers in humanitarian programming.

As part of a broader corporate effort to address the challenges raised by the multiplication of increasingly complex humanitarian crises, it is my hope that the results of this meta-analysis will be useful for UNFPA Executive Board and UNFPA management, as well as the humanitarian and fragile contexts branch, regional and country offices in shaping a more effective engagement of UNFPA in highly vulnerable contexts.

Marco Segone
Director, UNFPA Evaluation Office

EXECUTIVE SUMMARY

Introduction and methodology

In 2015, the UNFPA Evaluation Office launched a clustered country programme evaluation (CCPE) of UNFPA engagement in highly vulnerable contexts. The evaluation encompassed programme countries at high risk of a humanitarian crisis, as well as those facing and emerging from humanitarian situations, such as natural disasters, epidemics and armed conflicts. The CCPE comprised three sequential phases: (i) six country programme evaluations (CPEs); (ii) a synthesis of the results of the six country programme evaluations; and (iii) the present meta-analysis, which includes information from the wider circle of 25 UNFPA priority humanitarian countries. Countries selected for the country programme evaluations were Bangladesh, the Democratic Republic of the Congo (DRC), Haiti, Liberia, Myanmar and Nepal.

The meta-analysis is a lighter exercise than a full evaluation. Its purpose is to generate learning on UNFPA engagement in highly vulnerable contexts, with a view to improving future programming within the context of the UNFPA Strategic Plan 2018-2021. It does not assess country-level results, but establishes the degree to which UNFPA is able to provide efficient and effective emergency support in future, as per its mandate. The temporal scope puts a particular emphasis on the UNFPA Strategic Plan 2014-2017 period. The primary intended users are the UNFPA Humanitarian and Fragile Contexts Branch (HFCB) as well as UNFPA regional and country offices.

The meta-analysis was managed by the CCPE coordinator at the Evaluation Office, Mr. Hicham Daoudi, and was closely followed by a reference group composed of representatives from the country offices participating in the CCPE, representatives from UNFPA regional offices and a representative from HFCB. The reference group defined the seven meta-analysis themes, based on which the consultant formulated the meta-analysis questions. Data was collected through document review, semi-structured interviews with UNFPA staff and—to a lesser extent—external stakeholders, as well as electronic surveys.

Findings

Sexual and reproductive health and reproductive rights (SRH and RR): UNFPA country offices prioritized the Minimal Initial Service Package for Reproductive Health in Emergencies (MISP). Facilitated by the uptake of sexual and reproductive health and reproductive rights and the MISP at global and regional levels, good progress was made towards its inclusion in the humanitarian sector and implementation. Participation in overarching planning processes encouraged the involvement of other actors and leveraged funding. Conducting MISP trainings seems to have been a comparatively frequent activity, as was the assembly and delivery of emergency reproductive health kits, for which UNFPA is in charge internationally, and for which demand has grown. Responding to the needs of survivors of sexual violence is an important responsibility, but can be very difficult. Factors impeding MISP planning and implementation were, namely, direct competition with classic emergency relief, small national health budgets and weak national capacities, cultural sensitivities, insufficient UNFPA funds, staff shortages, and a lack of humanitarian coordination mechanisms. Sub-national presence and strong implementing partners helped considerably; as did anticipation of, and pre-positioning for, recurring crisis situations.

Gender-based violence (GBV): UNFPA country offices prioritized the issue of gender-based violence in emergencies. Engagement was facilitated by the formal designation of UNFPA as lead of the gender-based violence area of responsibility. UNFPA worked towards incorporating gender-based violence standards and interventions in contingency and response plans; it also engaged to improve gender-based violence information management in humanitarian contexts. Experience with dignity kits differed and challenges mainly pertained to procurement, contents and distribution. Pre-positioning cut delivery time and raised visibility. Some concerns were voiced that UNFPA did not sufficiently follow up and reintegrate gender-based violence survivors once an acute emergency situation had passed. It was also criticised for lack of corporate guidance. There were instances of poor international awareness and recognition of gender-based violence as a humanitarian issue

as well as instances where gender-based violence came second to more visible needs. Sensitivities and stigma also posed challenges. The lessons learned from the evaluation were that systematically pursuing synergies with sexual and reproductive health in emergencies is beneficial; that establishing working relations with strong local partners is crucial; and that emergencies can increase the willingness of decision-makers to tackle gender-based violence in the long-term. UNFPA country offices have not always had the necessary budgets and expertise at their disposal, such as for preparedness work and engaging in advocacy and policy dialogue.

Data for emergency preparedness and response: UNFPA has supported programme countries in data collection and analysis with a view to strengthening capacities for better preparedness, recovery and needs assessments at the onset of emergencies. UNFPA has generated data for humanitarian programming with the help of population censuses and sample household surveys. It also experimented with geo-referencing. Its involvement in needs assessments has increased. However, in most countries, this area of work is not as advanced as its work in the areas of sexual and reproductive health, reproductive rights and gender-based violence. Across the globe, UNFPA is not the "go-to" agency for generating data and is not playing a leading role in data collection and analysis. Political instability and weak national systems have hindered the ability of UNFPA to engage. Low levels of funding, insufficient human resources and missed opportunities to engage population and development officers in humanitarian programming have also hampered UNFPA ability. Corporate guidance and tools for operationalizing UNFPA commitment to increase investment in data in emergencies are inadequate.

Humanitarian-development nexus: UNFPA has committed itself to the "new way of working" as described in the Commitment to Action, signed by the Secretary-General and eight United Nations principals at the World Humanitarian Summit. This commitment frames the work of development and humanitarian actors, along with national and local counterparts, in support of collective outcomes towards the achievement of the Sustainable Development Goals. In 2017, the Executive Board commended the Fund for its invaluable work to bridge the humanitarian-development divide. Staff interviews and survey responses suggested similar understandings: the relevance of mutually inter-linking humanitarian assistance and development work for the benefit of vulnerable societies and communities was recognized. Such work helps these societies and communities prepare for, survive and recover from shocks. The disadvantages of development and humanitarian actors working in silos was also recognized. Working across the nexus has consequences for UNFPA alignment with country-level strategic frameworks, programme focus, modes of engagement, choice of implementing partners, geographical coverage and operations. In some places, perceived barriers to operating across different forms of aid included insufficient awareness, the lack of a strong corporate position, resource gaps, and separate structures and mechanisms. (Re)introducing comprehensive reproductive health services appears to be a particularly complex challenge.

Coordination and leadership: Where there is a sexual and reproductive health sub-cluster or similar mechanism at country level, UNFPA has played a leading role. However, this does not seem to be automatic nor should it be taken for granted. The guiding role of UNFPA in sexual and reproductive health humanitarian coordination is affected by the fact that there is no sexual and reproductive health area of responsibility within the Inter-Agency Standing Committee (IASC) cluster architecture, a fact that interviewed staff widely regretted. At times, the mere creation of a coordination mechanism was considered a success in itself. It depends on the level of stakeholder engagement in sexual and reproductive health and reproductive rights, which is often less than for classic humanitarian concerns, and the extent of competition for assuming a leading role. It also depends on stakeholder trust in the ability of UNFPA to lead, including at sub-national levels and during protracted crises. Future investments in human resources were considered vital for better reliability and credibility of the leading role of UNFPA.

UNFPA has many years of experience co-leading the gender-based violence area of responsibility of the protection cluster of the IASC. Interviewed staff considered this an advantage, but not a guarantee, for the existence of a functioning gender-based violence sub-cluster and for the undisputed leadership of UNFPA at country level. In 2016, 83 per cent of UNFPA programme countries affected by a humanitarian crisis had a functional inter-agency gender-based violence coordination body as a result of UNFPA coordination and leadership. At the beginning of 2017, UNFPA assumed sole leadership and thus even greater responsibility. Low stakeholder awareness and engagement and inadequate coordination expertise and financial resources pose important barriers.

UNFPA country programme design: UNFPA country offices working in highly vulnerable contexts strived to construct their country programmes on data, evidence and lessons learned. It is at least likely that they

gathered and analysed new data for the specific purpose of designing country programmes. Vulnerable population groups were consulted as part of country programme design, either directly or through civil society representatives. UNFPA staff interviews and country office surveys suggested that it was important for UNFPA to be engaged in scenario planning and subsequent programme adaptations throughout the programme cycle.

Operations: Funding for emergency preparedness and response programming remains insufficient. The regular resource allocation system was not revised to better take into account fragility and risk of humanitarian crises occurring. Although reliable and a timely source of funding, the UNFPA emergency fund has, measured against needs, faced resource constraints. Funding from external sources such as the United Nations Central Emergency Response Fund (CERF) has not met requirements. The humanitarian response reserve was not activated due to financial austerity measures. In view of the increasing emphasis on the humanitarian-development nexus, the flexible use of humanitarian and development funds has become even more relevant. Looking ahead, more effective resource mobilization will be key.

It appears that UNFPA runs a real risk of overwhelming country office staff working in highly vulnerable contexts. Work-life balance is an issue. Interviews called for more dedicated humanitarian aid staff capacities to credibly engage with other humanitarian actors. Sub-national level presence has been invaluable for UNFPA engagement. Areas of expertise required for working in highly vulnerable contexts are preparedness planning and disaster risk reduction; procurement and logistics; monitoring and evaluation in emergencies; and humanitarian coordination. There has been a process to develop surge capacity for responding to humanitarian situations, and this has been very useful, but clearly not sufficient to fill long-term capacity gaps. Country offices have not been able to rely on surge personnel being deployed in a timely manner and with the necessary competences.

UNFPA headquarters and regional offices provided useful support to country offices, although the very few regional office humanitarian focal points/coordinators were not always able to respond to all requests. Concrete benefits were noted in the areas of human resources deployment; resource mobilization; humanitarian commodities procurement and logistics; advocacy and communications; humanitarian mainstreaming; MISP capacity building; GBViE leadership and coordination; and the creation of a sub-national humanitarian hub.

Pre-positioning at regional, national and sub-national levels has been a particularly important aspect of UNFPA emergency preparedness work in highly vulnerable contexts, especially when humanitarian crises can be anticipated. While there are very good examples, procurement has posed difficulties in delivering on the UNFPA mandate. Consequently, UNFPA has not received the recognition and respect it requires as a humanitarian actor. Reasons for this include the absence of an organisation-wide comprehensive supply chain management strategy for humanitarian settings; reliance on central procurement; stock outs; delays; corporate barriers to pre-positioning; inadequate procurement and logistics management knowledge at country level; and little use of logistics partnerships.

The revised UNFPA fast-track procedures provided operational authority and flexibility, especially in terms of staff recruitment and commodities procurement. Still, there appears to be room to further increase operational flexibility in protracted emergencies, fragile contexts and high-security settings. Nimbler procedures—for example, automatic activation for all emergency levels—would allow UNFPA to reach its full potential in effectively and efficiently addressing vulnerabilities.

Conclusions and suggestions

Conclusion 1: A fair basis has been laid for UNFPA to position itself strategically and programmatically within the humanitarian-development nexus.

Suggestions:

1.1 Develop a strong corporate strategy on working across the humanitarian-development-peace nexus

1.2 Produce case studies on linking development and humanitarian approaches in UNFPA niche areas

1.3 Work towards more flexibility to shift financial resources from emergency to development interventions and vice versa

Conclusion 2: UNFPA humanitarian programming has grown, but funding is not commensurate with population needs, stakeholder expectations and corporate commitments in highly vulnerable contexts.

Suggestions:

2.1 With the aim of enhancing the capability of country offices to adequately finance their emergency and response plan, including by leveraging additional other resources, use the mid-term review of the UNFPA Strategic Plan 2018-2021 to adapt the UNFPA resource allocation system (RAS) by (i) introducing funding floors and (ii) better reflecting fragility and risk

2.2 Put a stronger focus on preparedness in UNFPA country programmes to reduce humanitarian needs

2.3 Work towards more flexibility to shift financial resources from development to emergency interventions

2.4 Continue to promote UNFPA as a humanitarian agency

2.5 Continue to promote sexual and reproductive health and reproductive rights and gender-based violence as frontline interventions

2.6 Elaborate a UNFPA-wide resource mobilization strategy for humanitarian situations

Conclusion 3: UNFPA staff in highly vulnerable contexts are frequently thinly stretched, which impacts on their well-being and performance and the reputation of UNFPA as a humanitarian actor.

Suggestions:

3.1 Review office structuring to meet strategic plan humanitarian requirements

3.2 Ensure adequate presence of dedicated humanitarian staff in priority humanitarian countries

3.3 Ensure that UNFPA staff are capable of working more flexibly across humanitarian and development programmes

Conclusion 4: The roles of UNFPA as leader of sexual and reproductive health and gender-based violence humanitarian coordination are meaningful and appreciated, but lack a solid footing.

Suggestions:

4.1 Continue to work towards better recognition of sexual and reproductive health and reproductive rights within the IASC cluster architecture

4.2 Emphasize inclusion of sexual and reproductive health and reproductive rights and gender-based violence in humanitarian contingency plans

4.3 Review and adjust coordination capacities in UNFPA priority humanitarian countries

4.4 Profit from lead roles to promote an integrated approach to sexual and reproductive health and gender-based violence programming in emergencies

Conclusion 5: UNFPA is at a crossroads on whether to invest in becoming a "go-to" agency for humanitarian data or to accept a more modest role.

Suggestions:

5.1 Clarify expectations underlying "increasing investment in data in emergencies" as per the UNFPA Strategic Plan 2018-2021

5.2 Update the 2010 UNFPA Guidelines for Data Issues in Humanitarian Crisis Situations

5.3 Ensure availability of adequate expert headquarter/regional office support for country offices

5.4 Explore options for better using/integrating population and development officers in humanitarian programming

Conclusion 6: UNFPA systems and processes for procuring and delivering humanitarian supplies are in need of a revamp.

Suggestion:

6.1 Commission an independent evaluation of UNFPA humanitarian supplies procurement and delivery

1. INTRODUCTION TO THE CLUSTERED COUNTRY PROGRAMME EVALUATION

1.1 Context

The UNFPA flagship report State of the World Population 2015 is entitled "Shelter from the storm—A transformative agenda for women and girls in a crisis-prone world". Chapter 1 sums up what it means to live in a fragile world: "Natural disasters, especially floods and storms, occur twice as frequently today as 25 years ago. Conflicts, especially those within national boundaries, are driving millions from their homes. Conflict, violence, instability, extreme poverty and vulnerability to disasters are deeply interrelated conditions, which today prevent more than one billion people from enjoying the massive social and economic gains achieved since the end of the Second World War."

Even under stable conditions, sexual and reproductive health and reproductive rights issues are a leading cause of death and illness among women of childbearing age. Despite 60 per cent of maternal deaths occurring in humanitarian and fragile circumstances and the fact that women and children comprise nearly half of all refugees, sexual and reproductive health and reproductive rights needs are easily overlooked during emergencies such as epidemics, conflicts and natural disasters. Women and girls face heightened threats in highly vulnerable contexts: skilled birth attendance and emergency obstetric care often become unavailable, exacerbating the dangers to pregnant women; the absence of services and commodities increases the possibilities of contracting HIV and other sexually transmitted infections; the breakdown of protection systems often leads to a rise in gender-based violence (GBV). In addition, the burden of care that women assume for children and others makes it difficult for them to take proper care of themselves.

Crises affect the effectiveness, impact and sustainability of UNFPA. Therefore, in today's world, and particularly in highly vulnerable contexts, UNFPA is required to consciously engage in humanitarian programming to reduce the consequences of emergencies if and when they strike. For this, UNFPA works closely with national governments, local authorities, United Nations agencies, civil society organisations, but also women, young people and other population groups and communities to ensure that sexual and reproductive health, reproductive rights, gender-based violence and HIV are integrated into emergency preparedness and response.

During the first year of the UNFPA Strategic Plan 2014-2017, the world witnessed an unprecedented increase in the number and complexity of humanitarian crises. The capacities of development and humanitarian partners were stretched by conflicts, disasters and epidemics. These crises offset development gains, cost many lives and compounded the suffering of millions of people.[1] In 2014, UNFPA responded to 34 humanitarian crises, including the Ebola outbreak in West Africa and five Level 3 emergencies, in Central African Republic, Iraq, the Philippines, South Sudan and the Syrian Arab Republic.[2] UNFPA humanitarian response work reached 5.4 million women and girls with sexual and reproductive health/gender-based violence prevention services.[3]

In 2015, humanitarian crises escalated in scope and complexity, stretching response efforts and exerting pressure on dwindling aid resources. The world witnessed the largest forced displacement of people since World War II. As a consequence, 60 per cent of preventable maternal deaths took place in settings of conflict, displacement and natural disasters.[4] Climate change destroyed livelihoods, worsened poverty, compelled relocation, and compounded the vicious cycle of poverty and vulnerability. The intrinsic link between poverty and vulnerability to crises made the separation of humanitarian and development

1 2015 Report of the Executive Director, Progress made in implementation of the UNFPA Strategic Plan 2014-2017, paragraph 9 [2015 progress report].
2 IASC Level 3 (or L3) response. L3 responses are activated in the most complex and challenging humanitarian emergencies, when the highest level of mobilization is required, across the humanitarian system, to ensure that the right capacities and systems are place to effectively meet needs. https://www.unocha.org/where-we-work/current-emergencies. 2015 progress report, paragraph 12.
3 2015 progress report, table 1.
4 2016 Integrated midterm review and progress report on implementation of the UNFPA Strategic Plan, 2014-2017—Report of the Executive Director, paragraph 8 [2016 progress report].

activities unacceptable. The adoption of the Sendai Framework for Disaster Risk Reduction 2015-2030 and the Paris Agreement on climate change paved the way for a greater focus and commitment to tackle hazards and their environmental, technological and biological impacts.[5] In 2015, UNFPA humanitarian support provided life-saving assistance to an estimated 10.5 million people (mainly women, girls and youth). Around 9 million people were reached with essential sexual and reproductive health and gender-based violence services and 11,942 reproductive health kits were delivered. To provide the required services, 751 mobile clinics and 543 maternity homes/tents were operationalized, in addition to 430 safe spaces.[6]

In 2016, humanitarian emergencies continued to plague the world. Humanitarian emergencies affected 125.3 million people (over 30 million of whom were women and adolescent girls of childbearing age[7]), representing an increase of 81 per cent compared to 2014.[8] Thanks to UNFPA, 903 maternity tents or homes were operationalized, 1,232 mobile clinics provided, and 915 safe spaces supported in humanitarian settings. Over 16 million women and girls in humanitarian crises were reached with sexual and reproductive health and gender-based violence services.[9] The five largest UNFPA humanitarian operations countries were Iraq, Yemen, Syria, South Sudan and Nigeria.[10] In 2017, UNFPA reached 16 million people with humanitarian assistance in 58 countries affected by emergencies. In 53 countries, 10.8 million people were reached with sexual and reproductive health services; 3.9 million people in 51 countries were provided with services and information on gender-based violence. In 36 countries, 1.5 million adolescents were reached with adolescent sexual and reproductive health services.[11]

1.2 Clustered country programme evaluation of UNFPA engagement in highly vulnerable contexts

In 2015, as per the UNFPA Quadrennial Budgeted Evaluation Plan 2016-2019 and in view of the growing share of humanitarian assistance within the Fund's portfolio of activities, the UNFPA Evaluation Office launched a clustered country programme evaluation of UNFPA engagement in highly vulnerable contexts.

In consultation with the UNFPA Humanitarian and Fragile Context Branch (HFCB), it was decided to focus the CCPE on the concept of vulnerability, including emergency preparedness and response, to ensure programmatic alignment with agreed international frameworks, as well as internal UNFPA discussions on humanitarian programming for building resilience.[12] As such, "highly vulnerable contexts" in the evaluation title was understood to encompass countries at high risk of a humanitarian crisis occurring (nationally, locally or limited to certain population groups) as well as those facing and emerging from humanitarian situations such as natural disasters, epidemics and armed conflicts.[13]

Countries selected for the CCPE were Bangladesh, the Democratic Republic of the Congo (DRC), Haiti, Liberia, Myanmar and Nepal. Based on lessons learned from the Bangladesh country programme evaluation, which served as a pilot, an approach paper was developed.[14] It provided a reference methodological framework for the remaining country programme evaluations. Questions and assumptions for assessment specifically addressing vulnerability were developed for inclusion in otherwise standard UNFPA country programme evaluations (see Box 1).

The CCPE comprised three sequential phases: (i) the conduct of six country programme evaluations; (ii) a

5 2016 progress report, paragraph 9.
6 DP/FPA/2017/CRP.3: UNFPA humanitarian response funding, 5 January 2017.
7 2017 Progress report on implementation of the UNFPA Strategic Plan 2014-2017. Report of the Executive Director, annex 4 [2017 progress report].
8 2017 progress report, paragraph 10.
9 2017 progress report, figure 2.
10 2017 progress report, annex 4.
11 Humanitarian Action 2018 Overview.
12 Resilience: "The ability of a system, community or society exposed to hazards to resist, absorb, accommodate to and recover from the effects of a hazard in a timely and efficient manner, through the preservation and restoration of its essential basic structures and functions". Source: UNISDR 2015.
13 Approach paper: Clustered country programme evaluation of UNFPA engagement in highly vulnerable contexts, UNFPA 2016, p. 6-7.
14 Approach paper: Clustered country programme evaluation of UNFPA engagement in highly vulnerable contexts, UNFPA 2016.

synthesis of the results of the six country programme evaluations; and (iii) the present meta-analysis.

Four country programme evaluation reports for Bangladesh, Haiti, Myanmar and Nepal were initially available and fed into the synthesis (Table 1). A draft report for Liberia was received on 29 September 2017 and added to the synthesis. The DRC report was received on 7 November 2017 and included alongside other information in the meta-analysis. All six reports were externally assessed as being of good or very good quality.

BOX 1:
Clusterd country programme evaluation questions and assumptions for assessment

Relevance

EQ: How did UNFPA take into account the country's vulnerability to disasters and emergencies in planning and implementing its interventions?

A.1: The UNFPA country programme was influenced by sound risk analyses

A.2: The country programme results and resource framework was revised to reflect the country's vulnerability following the adoption of the UNFPA Strategic Plan 2014-2017

Effectiveness

EQ: To what extent was UNFPA, along with its partners, likely to respond to crises during the period covered by the country programme? Where applicable: to what extent was UNFPA, along with its partners, able to respond to crises during the period covered by the country programme?

A.1: UNFPA contributed to the country's enhanced emergency preparedness

A.2: Where applicable, UNFPA successfully responded to crises during the period covered by the country programme

Efficiency

A.1: UNFPA put in place emergency preparedness measures to deliver at the onset of a crisis

UNCT coordination

A.1: UNFPA positioned itself well to enhance the UNCT emergency preparedness and response (where applicable)

Added value

A.1: UNFPA adds benefits to the humanitarian interventions of other development/humanitarian partners

Source: Approach paper

TABLE 1:
Availability and quality of clusterd country programme evaluations

	Evaluation report	*Quality assessment*	*Overall quality rating*
Bangladesh 2012-2016	Yes	Yes	Good
DRC 2013-2017	Yes	Yes	Good
Haiti 2013-2016	Yes	Yes	Good
Liberia 2013-2017	Yes	Yes	Good
Myanmar 2012-2017	Yes	Yes	Very good
Nepal 2013-2016	Yes	Yes	Very good

Source: UNFPA Evaluation Database/UNFPA Evaluation Office

2. META-ANALYSIS PROCESS AND METHODOLOGY

2.1 Purpose, objectives and scope of the meta-analysis

The purpose of this meta-analysis is to generate learning on UNFPA recent past and current engagement in highly vulnerable contexts, with a view to improving future programming, within the context of the UNFPA Strategic Plan 2018-2021.

The meta-analysis is a lighter exercise than a full evaluation. Consequently, its main purpose is learning (as opposed to accountability). It does not intend to provide a comprehensive picture of, or assess the extent to which, UNFPA interventions have resulted in country-level results, but rather to establish the degree to which UNFPA is in a position to provide efficient and effective emergency support in future, as per its mandate. More specifically, the objectives of the meta-analysis are to:

- Draw lessons on the performance of UNFPA engagement in highly vulnerable contexts based on the six country programme evaluations of the cluster
- Validate and complement this country-based body of findings and lessons learned through additional data collection and analysis work, with a view to reaching generalizable conclusions
- Propose a set of strategic and operational recommendations[15] for future UNFPA programmes and interventions in highly vulnerable contexts.

The meta-analysis does not make country-specific recommendations or attempt to differentiate between regions or categories of emergencies.

At the centre of the meta-analysis are the six country programme evaluation reports and the synthesis of their evaluation results. However, the meta-analysis goes beyond a desk review of the country programme evaluation reports. By extending the scope to combining a broader range of countries, stakeholders and documents, the meta-analysis is more comprehensive as it aims to provide a better understanding and insights for future UNFPA humanitarian work in general, both emergency preparedness and response.

The temporal scope of the meta-analysis dates from the beginning of the country programmes evaluated through the cluster country programme evaluations (2012) to date, with particular emphasis on the UNFPA Strategic Plan 2014-2017 period. This allows the analysis to update information contained in cluster country programme evaluations and other evaluations.

Applying a metaphor of concentric circles, the inner circle of countries included in the meta-analysis are the six country programme evaluations. A wider circle contains those 25 countries at the top of the 2018 INFORM Index for Risk Management.[16] Those countries face a very high or high risk of a humanitarian crisis occurring, which UNFPA has defined as countries with humanitarian crises—specifically Somalia, South Sudan, Chad, Afghanistan, Central African Republic, Yemen, Niger, DRC, Sudan, Syria, Iraq, Myanmar, Pakistan, Ethiopia, Haiti, Nigeria, Cameroon, Libya, Mali, Mozambique, Uganda, Kenya, Bangladesh, Burundi, and Tanzania.[17] Four of the six country programme evaluations in the inner circle are also amongst these countries at highest risk (Liberia and Nepal are not). A third circle picks up on information provided for other programme countries in an "opportunistic" manner, in particular, further countries at risk or at high risk according to the 2018 INFORM index.[18]

15 It should be noted that later in the process it was agreed to use the term "suggestions" in order to draw a distinction between a meta-analysis and an evaluation.

16 INFORM is a collaborative project of the IASC and the European Commission. It uses 50 indicators and 17 components to measure 3 risk dimensions: hazards and people's exposure to them; vulnerability; and lack of coping capacity (or the amount and type of resources available to help people cope). For more information: http://www.inform-index.org/. UNFPA considers the top 25 countries to be those facing a humanitarian crisis.

17 The last SP metadata indicated 50 countries to be prioritized as high risk by UNFPA. However, following consultation with regional offices, the number of selected countries was reduced to 25 to ensure greater focus of UNFPA interventions on preparedness. Source: HFCB.

18 Including DPRK, Ukraine, Guinea, Papua New Guinea, Mauritania, Zimbabwe, Burkina Faso, and Angola where UNFPA country programmes were evaluated during the SP 2014-2017 cycle.

The primary intended users of the meta-analysis are the UNFPA Humanitarian and Fragile Contexts Branch as well as UNFPA regional and country offices.

2.2 Management and governance

The meta-analysis was managed by the CCPE coordinator at the Evaluation Office, Mr. Hicham Daoudi, with the support of research assistant Ms. Rosalie Fransen.

The progress of the study was closely followed by a reference group composed of representatives from the six country offices participating in the CCPE, representatives from UNFPA regional offices and a representative from HFCB (Annex 1). The reference group was not established to ensure an independent perspective (as is usually the case with evaluations), but was acting as a technical body and consisted of selected future users of the meta-analysis findings, conclusions and suggestions. It discussed the synthesis and the draft inception report on 28 September 2017 and the draft meta-analysis report at a stakeholder workshop in New York on 13 December.

2.3 Meta-analysis phases and timeline

The meta-analysis unfolded in three phases: (1) the inception phase, (2) the data collection phase and (3) the reporting phase.

(1) Inception phase: Inception report (Annex 2)

- Synthesis of the final reports of the cluster country programme evaluations
- Methodological framework for data collection, including (i) common themes and meta-analysis questions; (ii) mapping of evaluations and studies to be included in the document review; and (iii) stakeholder mapping for interviews and electronic survey.

In view of the first reference group meeting, a long list of 20 assumptions for analysis was submitted based on the synthesis of the four final country programme evaluation reports available at the time. The reference group meeting reviewed the assumptions and—based on their concrete information needs in the context of the UNFPA Strategic Plan 2018-2021 and anticipated evaluability of the assumptions—agreed on common themes for the analysis.

(2) Data collection and analysis phase

(3) Reporting phase: Final meta-analysis report

- Draft meta-analysis report containing findings, conclusions and suggestions for future UNFPA engagement in highly vulnerable contexts
- Stakeholder workshop in New York on 13 December 2017

A detailed timeline is included in Annex 3 of this report.

2.4 Synthesis

The synthesis (as part of the inception phase) built on the following analytical steps:

1. Relevant evidence and findings from four final country programme evaluations of the cluster "cut and paste" into a separate Word document along different evaluation criteria (if necessary re-arranged)
2. Evidence and findings tagged and common themes identified
3. Aggregation of evaluation results along the common themes
4. Evidence and findings from draft Liberia country programme evaluation report added to synthesis where relevant.

The synthesis was annexed to the inception report. It aggregated country programme evaluation results along identified common themes. Relevant synthesis findings have been integrated in the present meta-analysis in chapter 4. They are presented in full in Annex 4.

2.5 Meta-analysis themes and questions

Reference group members agreed on common themes for the meta-analysis. Based on these, the consultant formulated meta-analysis questions, which were subsequently approved by the Evaluation Office. The meta-analysis was conducted and structured along seven themes/questions and guided by indicative fields of analysis (Annex 5).

Theme 1: Sexual and reproductive health and reproductive rights. To what extent are UNFPA country offices in a position to support countries experiencing highly vulnerable contexts to meet the sexual and reproductive health needs of women and girls through the Minimum Initial Services Package?

Theme 2: Gender-based violence: To what extent are UNFPA country offices in a position to support countries experiencing highly vulnerable contexts to put in place gender-based violence protection mechanisms that prevent and respond to gender-based violence from the onset of an emergency?

Theme 3: Data for emergency preparedness and response. To what extent are UNFPA country offices in a position to support countries experiencing highly vulnerable contexts to ensure greater availability and use of disaggregated data for humanitarian programming?

Theme 4: Humanitarian-development nexus. To what extent are UNFPA country offices in a position to use a continuum of interventions interlinking humanitarian, transition and development programming?

Theme 5: Coordination and leadership. To what extent are UNFPA country offices in a position to contribute to and lead humanitarian coordination in the areas of gender-based violence, sexual and reproductive health and reproductive rights, especially within the cluster approach?

Theme 6: Evidence-based country programme design in highly vulnerable contexts. To what extent are UNFPA country offices in a position to reflect on fragile/humanitarian contexts and formulate support for emergency preparedness and response in country programme documents based on data, evidence and lessons learned?

Theme 7: Operations. To what extent are UNFPA country offices equipped to deliver efficient and effective support for emergency preparedness and response from an operational point of view?

2.6 Data collection

The following data collection methods were used:

- Document review
- Semi-structured interviews
- Electronic surveys

2.6.1 Document review

Annex 6 provides a list of reference documents. The document review did not systematically consider country-level documentation except for available country programme evaluations. In 2014 and 2016 respectively, UNFPA organized humanitarian consultations where challenges and major bottlenecks were identified, recommendations made, and a series of actions proposed in support of country offices. They are in various stages of implementation. Recommendations from the 2016 consultation are referred to below in the findings chapter and picked up in the conclusions and suggestions.

2.6.2 Interviews

Participants in the reference group meeting were invited to make suggestions for key informants—giving reasons for their suggestions, including what topics the key informants might usefully cover and what topics might be suitable for the survey. It was agreed that informants could be from global, regional or country level, within or outside UNFPA. However, further work on the meta-analysis methodology revealed that interviewing an emerging large number of stakeholders would not be feasible. Information gathered through semi-structured interviews (via Skype) was therefore initially limited to selected key informants from within UNFPA.

Interviews with UNFPA representatives and country directors of the UNFPA country offices in the six CCPE countries served to update and supplement evidence and findings contained in the country programme evaluation reports. The country programmes were not re-evaluated. Interviews with a sample of seven other UNFPA country offices were intended to validate and complement the body of evidence from the six country programme evaluations. Sampling was purposeful, selected by the Evaluation Office in consultation with HFCB, and attempted to balance regional perspectives

with country classification as much as possible. Twenty one interviews with UNFPA staff were envisaged between 6 and 28 November 2017 (Table 3). A total of 17 interviews were conducted (see Table 3 and Annex 7). It was not possible to schedule interviews with key informants in Iraq, Burundi and Chad within the given timeframe. The Bangladesh country office, acutely confronted with the Rohingya crisis, opted to respond to the long country office survey instead.

TABLE 3:
UNFPA staff interviews

Key informants	Interviews planned	Interviews conducted
HFCB, PSB	2	2
UNFPA regional offices	6	6
Representatives/country directors of UNFPA country offices in the CCPE countries (Bangladesh, DRC, Haiti, Liberia, Myanmar, Nepal)	6	5
Representatives/country directors in a sample of UNFPA country offices from the 25 in the meta-analysis universe (Burundi, Chad, Ethiopia, Iraq, Libya, Mozambique, Yemen)[1]	7	4
	21	**17**

The focus of the interviews with the 13 selected UNFPA country offices was on the substantive meta-analysis questions 1-5. Interviews with UNFPA regional offices covered all seven themes. Interviews with UNFPA headquarters were tailored to the interviewee in question. To facilitate preparation, interview guides (Annex 8) were shared beforehand.

2.6.3 Surveys

Interviews are the preferred manner for gaining in-depth information and understanding, and for identifying key issues, different opinions and perceptions. However, they require a substantial amount of time for preparing and conducting, and do not allow for gathering of evidence from a broader range of stakeholders. For this reason, three self-administered online surveys were conducted between 6 and 24 November 2017 (closed on 28 November).

Short UNFPA country office survey: The 13 country offices sampled for interviews were simultaneously invited to respond to a very short survey regarding the two process-related meta-analysis questions—specifically, evidence-based country programming (theme 6) and operations (theme 7).

Long UNFPA country office survey: In addition, the remaining 14 country offices in the meta-analysis were invited to participate in a survey covering all seven meta-analysis questions.

The country office surveys were sent by the Evaluation Office to the respective UNFPA representatives/country directors with the expectation that s/he consult with relevant colleagues.

External stakeholder survey: The external stakeholder survey focused on the substantive themes 1-5 and intended to cover all 27 countries subject to this analysis. Firstly, it was addressed to selected Inter-Agency Standing Committee (IASC[19]) partners at the global level and relevant Humanitarian Country Team members, especially with regard to the health and protection clusters (sexual and reproductive health and gender-based violence sub-clusters). Secondly, since governments retain the primary role in humanitarian assistance within their territories, the external stakeholder survey served to gather views of country-level government counterparts in emergency preparedness and response—specifically, national disaster management authorities and those government entities leading the health and protection clusters (sexual and reproductive health and gender-based violence sub-clusters).

19 The chair, members and standing invitees of the Inter-Agency Standing Committee (IASC) are the Emergency Relief Coordinator (chair), UNDP, UNICEF, UNHCR, WFP, FAO, WHO, UN-HABITAT, OCHA, IOM, the International Committee of the Red Cross (ICRC), the International Federation of Red Cross and Red Crescent Societies (IFRC), OHCHR, the Special Rapporteur on the Human Rights of IDPs, the World Bank, the International Council of Voluntary Agencies (ICVA), InterAction, and the Steering Committee for Humanitarian Response (SCHR). See https://interagencystandingcommittee.org/

The external stakeholder survey was sent by the Evaluation Office using a list of names and e-mail addresses supplied by HFCB and the UNFPA country offices, respectively. The surveys were developed in English and translated into French by the Evaluation Office.

2.7 Limitations and level of confidence

The very short time period for producing the draft meta-analysis report required availability of the Evaluation Office, HFCB, interviewees and survey participants to be available at very short notice. Despite strong involvement by the Evaluation Office, also in terms of organizing interviews and creating the online-survey, there was a risk that the tight timeline for interviews and surveys would result in a low survey response rate and a number of key informants not being consulted.

Six out of 15 country offices responded to the long country office survey (Annex 9),[20] thereby adding information regarding the five substantive themes to the interviews from UNFPA headquarters, six regional offices and nine country offices. A reasonable 7 of 12 country offices responded to the short country office survey (Annex 9). Together with those six responding to the long survey, valuable information regarding the two process-related themes was collected from 13 country offices (of the planned 27). Despite the tight timeframe, this represented a good coverage of the 27 programme countries, which included the 25 UNFPA priority humanitarian countries. Country-level primary data used in this meta-analysis originated from the following 16 countries: Afghanistan, Bangladesh, Burundi, DRC, Ethiopia, Haiti, Liberia, Libya, Myanmar, Mozambique, Nepal, Nigeria, Pakistan, Somalia, Uganda and Yemen.

However, the external stakeholder survey generated very low response rates. Not a single global partner responded; only 15 per cent and 11 per cent of planned country-level Humanitarian Country Team and government counterparts responded (Annex 9). To fill information gaps, it was subsequently decided to conduct interviews with select global partners. Six interviews were conducted with representatives of five partner organizations between 9 and 24 January 2018 (Annex 7).

20 Bangladesh opted to complete the long country office survey rather than supply key informants for interview and complete the short survey.

3. BACKGROUND: STRATEGIC AND POLICY FRAMEWORK

3.1 UNFPA Strategic Plan 2014-2017

3.1.1 Development and management results

UNFPA strategic plans occupy the highest level of strategic orientation within UNFPA. The UNFPA Strategic Plan 2014-2017 does not explicitly use the term vulnerable contexts. However, alongside references to humanitarian assistance, post-conflict situations and transition from emergency to development, it addresses emergency preparedness. Three of the strategic plan outcomes specifically relate to UNFPA engagement in vulnerable settings and UNFPA country offices are expected to deliver four outputs in connection with strengthening emergency preparedness and response. They are:

- Number of countries that have humanitarian contingency plans that include elements for addressing sexual and reproductive health needs of women, adolescents and youth including services for survivors of sexual violence in crises (outcome 1, output 5, indicator 5.2)
- Number of countries that have capacity to implement MISP at the onset of a crisis (outcome 1, output 5, indicator 5.1)
- Percentage of countries affected by a humanitarian crisis that have a functioning inter-agency gender-based violence coordination body as a result of UNFPA guidance and leadership (outcome 3, output 10, indicator 10.2)
- Proportion of countries experiencing a humanitarian crisis situation in which UNFPA provided technical assistance on the use of population-related data and support for assessments (outcome 4, output 12, indicator 12.1).

In addition, Organizational Effectiveness and Efficiency enable the achievement of development outputs and outcomes. The UNFPA Strategic Plan 2014-2017 requires UNFPA in "high risk" countries to have up-to-date humanitarian preparedness plans (Organizational Effectiveness and Efficiency: output 1, indicator 1.8).

The mid-term review of the UNFPA Strategic Plan 2014-2017 emphasised the need not only to react to disasters and conflicts, but to prepare and empower individuals, communities and institutions to withstand and recover from them—that is, to increase their resilience.[21] In recognition of the need for an expanded role for UNFPA in humanitarian settings, four indicators relevant to humanitarian and resilience were added to the revised integrated results and resources framework (IRRF).

- Countries that have mainstreamed risk reduction/resilience, inclusive of climate change into national health strategies and plans (outcome 1, indicator 11)
- Proportion of countries in early recovery stage where reproductive health facilities affected during crisis were rehabilitated (outcome 1, output 5, indicator 5.3)
- Number of peacebuilding countries that have institutional mechanisms to engage youth in the development of conflict mitigation programmes (outcome 1, output 6, indicator 6.3)
- Proportion of requests for surge deployment received from countries offices that were met (Organizational Effectiveness and Efficiency: output 2, indicator 2.13)

Annex 3 of the UNFPA Strategic Plan 2014-2017 regarding the business model of UNFPA, talks in more detail about UNFPA humanitarian programming.[22] Annex 3 references the UNFPA Second Generation Humanitarian Response Strategy, the "standard operating procedures" and "fast-track procedures", the creation of new dedicated posts for supporting humanitarian programming in regional offices, and the surge roster. It anticipates greater organizational focus on preparedness in line with the Inter-Agency Standing Committee's Transformative Agenda, the Quadrennial Comprehensive Policy Review of the United Nations Operational Activities

21 2016 progress report, paragraph 69.
22 SP 2014-2017, annex 3, paragraphs 25-34.

for Development (QCPR) and the Rio+20 outcome document. It also anticipates stronger partnerships with local stakeholders and United Nations agencies such as UNICEF and the World Food Programme to ensure the delivery of critical assistance and continuity of services in the event of a crisis. Furthermore, the intention is expressed for UNFPA to step up its leadership in gender-based violence within the humanitarian cluster coordination system. Lastly, the business model provides guidance for how UNFPA should engage in different country contexts. While not specifically talking about which modes of engagement apply in highly vulnerable contexts, it becomes evident that all modes of engagement are applicable, regardless of the colour quadrant to which countries belong.[23]

3.1.2 Funding arrangements

Annex 4 of the UNFPA Strategic Plan 2014-2017 on funding arrangements is also helpful for understanding the UNFPA approach to highly vulnerable contexts. It argues that "the world in which UNFPA works is highly unpredictable. Earthquakes or hurricanes can strike suddenly in areas that were previously calm and untroubled, while armed conflict can arise with little warning in countries that had been considered stable…". Consequently, a set of six indicators for allocating regular resources to UNFPA programme countries through the resource allocation system was supplemented by two other topics, one of which was "risk for humanitarian crises", and the other, detailed in annex 4, was called "fragility and risk for humanitarian crises".[24] Risk for humanitarian crises was included "because it is a factor that influences the ability of UNFPA to achieve impact, both by shifting the nature of the work that the organization carries out and by increasing the challenges (and thereby the costs) of delivering interventions".

Risk was to be assessed through the OCHA global focus model. The eight indicators for regular resource allocation, including the one for fragility and risk for humanitarian crises, were consequently assigned points. Countries facing the highest risks received an extra ten points, those facing high risk, six points, and those with a medium risk, three points.[25] A consequence of this was that a higher share of UNFPA regular resources should be allocated to countries facing the highest risks for humanitarian crises. Ultimately, since 2016, the INFORM Index for Risk Management has been the basis for identifying high-risk countries.[26]

A key funding mechanism used during 2014-2017 for allocating resources is the UNFPA emergency fund, established by the Executive Board in 2000,[27] to provide immediate funding for country offices to enhance timely, life-saving humanitarian assistance, with a focus on sexual and reproductive health and reproductive rights, gender-based violence and population data.[28] Initially, an amount of $1 million was set aside annually. This figure was raised to $3 million in 2006, $5 million in 2013 and $10 million in 2015.[29,30] The emergency fund is available to country offices for the following purposes:[31]

- Acute phases of emergencies. For all humanitarian assistance programmes (aimed at saving lives and alleviating suffering of a crisis-affected population) in response to armed conflicts or natural disastersChronic humanitarian situations. For country offices to expand the humanitarian response
- Preparedness planning. Contributing to the implementation of a national contingency or preparedness plan, or initiating or implementing minimum preparedness actions by the United Nations Country Team.

Funding is intended for countries facing crises based on the following criteria:[32]

- When regular country programme funds are not available
- When country programme funds are not immediately available, but could be used at a later date for reimbursement with the approval of the government

The humanitarian response reserve (HRR) was brought to life in 2015 with an intended one-off approved ceiling of $10 million of regular resources to act as a bridging

23 UNFPA modes of engagement: advocacy and policy dialogue; capacity development; knowledge management; partnerships and coordination; and service delivery. Please refer to Annex 3 of the UNFPA Strategic Plan 2017-2017: https://www.unfpa.org/sites/default/files/admin-resource/PD_Annex%203.%20Business%20model.pdf
24 SP 2014-2017, annex 4, paragraphs 62 and 78. The other was income inequality.
25 SP 2014-2017, annex 4, paragraph 87.
26 Evaluation of SP 2014-2017 architecture.
27 Executive Board decision 2000/13.
28 DP/FPA/2017/CRP.3: UNFPA humanitarian response funding, 5 January 2017.
29 Executive Board decision 2015/3.
30 Evaluation of SP 2014-2017 architecture, p. 26.
31 DP/FPA/2017/CRP.3: UNFPA humanitarian response funding, 5 January 2017.
32 SP 2014-2017, annex 4, paragraph 110; DP/FPA/2017/CRP.3: UNFPA humanitarian response funding, 5 January 2017.

fund for country offices pending receipt of donor funds.[33] It remains unfunded due to corporate financial austerity measures.

3.2 UNFPA Strategic Plan 2018-2021

The UNFPA Strategic Plan 2018-2021 is aligned with the 2030 Agenda for Sustainable Development and its 17 Sustainable Development Goals. It also intends to respond to other global frameworks underpinning the 2030 Agenda, including the Sendai Framework for Disaster Risk Reduction 2015-2030 of the Third United Nations World Conference on Disaster Risk Reduction, the 2015 Paris Agreement on climate change and the 2015 Addis Ababa Action Agenda of the Third International Conference on Financing for Development. The strategic plan recognises the increasing number of multidimensional humanitarian crises, including protracted conflicts, across the world. Meeting the needs of women and girls in volatile humanitarian and fragile contexts remains a critical focus. The strategic plan change model is underpinned by the principles of reducing risk and vulnerabilities and building resilience, as well as strengthening cooperation and complementarity among development and humanitarian action.

Sixteen indicators that assess the progress of UNFPA humanitarian and resilience-building work are included in the integrated results and resources framework. They are listed below and referred to in the findings chapter:

EMERGENCY PREPAREDNESS AND RESPONSE-RELATED INDICATORS IN UNFPA INTEGRATED RESULTS AND RESOURCES FRAMEWORK:

Total lives saved (goal, indicator 8)

Number of deaths, missing persons and directly affected persons attributed to disasters per 100,000 population (goal, indicator 9)

Number of women, adolescents and youth who have utilized integrated sexual and reproductive health services (meta data mentions in humanitarian settings) (outcome 1, indicator 1)

Number of countries that have budgeted emergency preparedness and response and disaster risk reduction plans that integrate sexual and reproductive health (outcome 1, output 1, indicator 1.3)

Number of health service providers and managers trained on the minimum initial service package with support from UNFPA (outcome 1, output 3, indicator 3.4)

Number of countries that have used a functional logistics management information system, including "reaching the last mile", for forecasting and monitoring essential medicines and supplies, including sexual and reproductive health commodities (disaggregation for humanitarian settings) (outcome 1, output 4, indicator 4.2)

Proportion of countries affected by a humanitarian crisis that have a functioning inter-agency sexual and reproductive health coordination body as a result of UNFPA guidance and leadership (outcome 1, output 5, indicator 5.4)

Number of countries that have institutional mechanisms for the participation of young people in policy dialogue and programming, including peace-building processes (outcome 2, output 8, indicator 8.1)

Proportion of countries responding to humanitarian crises that included young people in decision-making mechanisms in all phases of the humanitarian response (outcome 2, output 8, indicator 8.2)

Number of countries that have applied the minimum standards for the prevention of, and response to, gender-based violence in emergencies (outcome 3, output 11, indicator 11.4)

Proportion of countries affected by a humanitarian crisis that have a functioning inter-agency gender-based violence coordination body as a result of UNFPA guidance and leadership (outcome 3, output 11, indicator 11.5)

Proportion of countries that experienced humanitarian crises and that conducted rapid assessments of the affected populations, including pregnant women (outcome 4, output 13, indicator 13.4)

Proportion of high-risk countries that produced a common operational data set on population statistics (outcome 4, output 13, indicator 13.5)

Proportion of countries that generated and used mapping (at the district level or below) to illustrate the vulnerability of their population to disasters and humanitarian crises (outcome 4, output 14, indicator 14.4)

Proportion of field offices that implemented the UNFPA minimum preparedness actions (Organizational Effectiveness and Efficiency: output 1, indicator 1.11)

Proportion of humanitarian emergencies in which surge deployment was achieved within lead response time (Organizational Effectiveness and Efficiency: output 2, indicator 2.3).

Source: IRRF/HFCB

33 Executive Board decision 2015/3; Evaluation of SP 2014-2017 architecture.

UNFPA intends to give priority and allocate a higher share of regular resources (approximately 60 per cent) to countries with a combination of (i) highest need and low or lower-middle level ability to finance their programme; and (ii) high need and low ability to finance (red quadrant). The strategic plan also acknowledges that country offices in the red quadrant will require a larger number of staff, including staff with experience in managing complex programmes. Financial needs are determined by a set of pre-defined indicators, including the "humanitarian/risk factor" (on the basis of INFORM data).[34]

UNFPA presence at the country level is operationalized through five modes of engagement, namely, advocacy and policy dialogue; capacity development; knowledge management; partnerships and coordination; and service delivery. UNFPA will deploy all five modes of engagement for countries in the red quadrant and countries with humanitarian crises (the latter irrespective of their colour coding).[35]

The UNFPA Strategic Plan 2018-2021 business model clarifies that a country's evolving humanitarian condition over the course of 2018-2021 does not suggest a change in colour quadrant, but rather a rapid change in the mode of operation, deployment of support, and programming.[36]

According to the UNFPA Strategic Plan 2018-2021, UNFPA will strengthen humanitarian operational capacity to better meet the needs of affected populations. This includes: (i) aligning human resources capacity to deliver in humanitarian contexts; (ii) strengthening humanitarian advocacy and communications; (iii) increasing investment in data in emergencies; (iv) promoting strategic partnerships to advance effective humanitarian action; and (v) providing effective leadership in gender-based violence.[37] In addition, regional interventions, complemented by global interventions, should provide frontline support to countries in regions that are prone to disasters and humanitarian crises.[38]

3.3 Main global frameworks

This background chapter very briefly references the principal initiatives and global frameworks to which UNFPA contributed and to which it reports in connection with its work in vulnerable and humanitarian contexts. Document review points towards the following relevant global frameworks:

- 2011 Inter-Agency Standing Committee's Transformative Agenda (and subsequent revisions)
- Future We Want—Rio+20 Outcome document (2012)
- 2015 Paris Agreement on climate change
- Sendai Framework for Disaster Risk Reduction 2015-2030
- 2030 Agenda for Sustainable Development
- A/RES/71/127 Strengthening of the coordination of emergency humanitarian assistance of the United Nations
- World Humanitarian Summit Commitments to Action (2016)
- World Humanitarian Summit Compact for Young People in Humanitarian Action (2016)
- Grand Bargain (2016)
- 2016 Quadrennial Comprehensive Policy Review of United Nations Operational Activities for Development (QCPR)
- Global Strategy for Women's, Children's and Adolescents' Health 2016-2020
- Sphere Handbook, Humanitarian Charter and Minimum Standards in Humanitarian Response

34 UNFPA SP 2018-2021 paragraphs 45, 46, 48, 54 and 57. The humanitarian/risk factor maintains a 10-point weight, as in the previous resource allocation system.
35 UNFPA SP 2018-2021 paragraphs 50 and 51.
36 UNFPA SP 2018-2021, annex 4, paragraph 20.
37 UNFPA SP 2018-2021, annex 4, paragraph 38.
38 UNFPA SP 2018-2021, paragraph 86.

3.4 Implementation guidance

UNFPA has (co-)produced a range of guidance on the emergency preparedness and response dimensions of its work, as alluded to before. Without going into details, attention is drawn to:

- Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings (2009)
- Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (2010)
- IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2005 (revised 2015)
- Guidelines on Data Issues in Humanitarian Crisis Situations (2010)
- Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations: A Distance Learning Module (revised 2011)
- Manual: Inter-Agency Reproductive Health Kits for Crisis Situations (2011)
- ·UNFPA Humanitarian Response Strategy "Second Generation" (2012)
- Dignity Kit Programming Guidelines (2013)
- UNFPA Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies (2015)
- Humanitarian Programming in the Strategic Plan Business Model: Operational Guidance for UNFPA Internal Use (2015)
- Guidance Note on Minimum Preparedness, revised version (8 June 2016)
- The UNFPA Standard Operating Procedures for Humanitarian Settings, Working Document (2017)
- UNFPA Fast-Track Policies and Procedures, issued on January 2012, August 2015 revision

4. FINDINGS OF THE META-ANALYSIS

4.1 Sexual and reproductive health and reproductive rights

To what extent are UNFPA country offices in a position to support countries experiencing highly vulnerable contexts to meet the sexual and reproductive health needs of women and girls through the minimum initial services package?

SUMMARY: UNFPA COUNTRY OFFICES HAVE PRIORITIZED THE MISP AND GOOD PROGRESS HAS BEEN MADE TOWARDS ITS INCLUSION AND IMPLEMENTATION.

MISP inclusion in the humanitarian sector and MISP implementation have been facilitated by the uptake of sexual and reproductive health and reproductive rights and the MISP at global and regional levels. Participation in overarching planning processes has supported the inclusion of sexual and reproductive health and reproductive rights as a sub-sector as well as the mainstreaming of MISP elements in other sectors. This, in turn, facilitated the involvement of development and humanitarian partners and leveraged funding. Inclusion of sexual and reproductive health and reproductive rights/MISP in humanitarian plans creates expectations in terms of UNFPA implementation support. Conducting MISP trainings seems to be a comparatively frequent activity, as is the assembly and delivery of emergency reproductive health kits, for which UNFPA is in charge internationally, and for which demand has grown. Responding to the needs of survivors of sexual violence is an important responsibility, but can be very difficult. Factors impeding MISP planning and implementation are direct competition with classic emergency relief and small national health budgets and weak national capacities. Cultural sensitivities, as well as insufficient UNFPA funds, staff shortages and missing humanitarian coordination mechanisms also impact MISP planning. Sub-national presence and strong implementing partners have helped considerably, as has active anticipation of, and pre-positioning for, recurring/seasonal crisis situations.

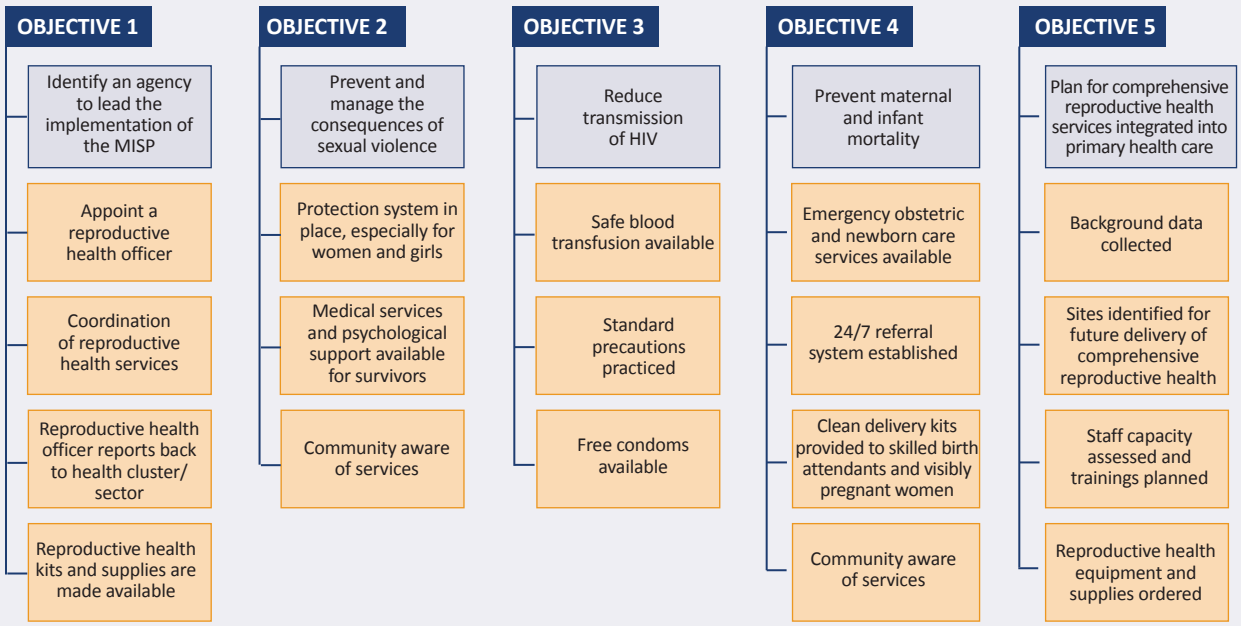
The Minimum Initial Service Package for Reproductive Health in Emergencies (MISP) was developed by the Inter-Agency Working Group on Reproductive Health in Crises, of which UNFPA is a member.[39] It is a series of life-saving actions required to respond to reproductive health needs at the onset of a humanitarian crisis that ought to be implemented in a coordinated manner by appropriately-trained persons. MISP actions are sustained and expanded with comprehensive reproductive health services throughout protracted crises and recovery. The objectives of the MISP are described in the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings and can be summarised as follows (for more details, see Figure 1):

- Identify an organization to lead the implementation of the MISP
- Prevent and manage the consequences of sexual violence
- Reduce HIV transmission
- Prevent maternal and new-born death and illness
- Plan for comprehensive sexual and reproductive health care, integrated into primary health care, as the situation permits.

The MISP was included as a Sphere standard[40] in 2004, followed in 2010 by its inclusion as a life-saving intervention eligible for United Nations Central Emergency Response Fund (CERF) funding.[41] The MISP is currently under revision by the Inter-Agency Working Group on Reproductive Health in Crisis and the revised Inter-Agency Field Manual is expected for 2018.[42]

39 http://iawg.net/about-us/. Also see Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, 2010.
40 http://www.sphereproject.org/.
41 Central Emergency Fund Lifesaving Criteria and Sectoral Activities Guidelines 2010.
42 November 2017 Evaluation of ERH Kits.

FIGURE 1:
Minimum initial service package objectives



Source: www.unfpa.org

UNFPA country offices have prioritized the MISP and good progress has been made towards its inclusion in emergency preparedness and response planning and implementation. Five out of six country offices responding to the survey felt they were sufficiently prioritizing the MISP.

MISP inclusion in humanitarian planning

Indicator 5.2 of the UNFPA Strategic Plan 2014-2017 expected an increase in the number of countries that have humanitarian contingency plans with elements for addressing sexual and reproductive health needs of women, adolescents and youth including services for survivors of sexual violence in crises. Indicator 1.3 of the UNFPA Strategic Plan 2018-2021 anticipates an increase in the number of programme countries that have budgeted emergency preparedness and response and disaster risk reduction plans that integrate sexual and reproductive health.

In 2014, 50 programme countries were reported to have humanitarian contingency plans that included elements for addressing the sexual and reproductive health needs of women, adolescents and youth, many of which were set up and supported by UNFPA.[43] For example, in Myanmar, UNFPA supported the ministry of health and sports to develop a humanitarian contingency plan that included elements to address the sexual and reproductive health needs of women, adolescents and youth, including services for survivors of sexual violence in crises;[44] UNFPA successfully supported the Government of Turkmenistan to develop a national MISP action plan.[45]

Besides facilitating the inclusion of sexual and reproductive health and reproductive rights as a sub-sector, participation in overarching planning processes has supported mainstreaming of MISP elements in other sectors and thus helped leverage additional partners and funding, including for UNFPA. Inclusion has also occurred and is deemed important at sub-national level. For example, in Sudan, state-level emergency preparedness and response plans were prepared/updated subsequent to UNFPA-supported MISP trainings.[46]

43 2015 progress report, table 1.
44 UNFPA Country Programme Evaluation: Myanmar, CP3: 2012-2017.
45 Lessons learned, p. 22.
46 UNFPA Country Programme Evaluation: Sudan, Final Evaluation Report, 6th Cycle Programme 2013-2016.

Often, because of poor international awareness and recognition of sexual and reproductive health and reproductive rights as a humanitarian issue, MISP inclusion in humanitarian contingency/response plans has clearly suffered from direct competition with classic emergency relief such as food, nutrition and water. The more recent uptake of sexual and reproductive health and reproductive rights and specifically the MISP at global and regional levels in several significant recent policy documents and United Nations resolutions, is therefore considered central. For example, the Sendai Framework for Disaster Risk Reduction 2015-2030.

MISP implementation

Successful inclusion of sexual and reproductive health and reproductive rights/MISP in contingency/response plans creates expectations. As much as possible, UNFPA has also supported MISP implementation, including MISP trainings, rendering feasible clinical care for survivors of rape, and delivering emergency reproductive health kits.

Indicator 5.1 of the UNFPA Strategic Plan 2014-2017 tracked the number of countries with the capacity to implement MISP at the onset of a crisis. Indicator 3.4 of the UNFPA Strategic Plan 2018-2021 measures the extent to which the number of health service providers and managers trained on the MISP increases. Capacity building and conducting MISP trainings seems to be a comparatively frequent activity.

In 2014, UNFPA helped to train partners in 48 countries to implement the MISP at the onset of humanitarian crises. By 2015, 57 countries had the capacity to implement the MISP, and by 2016, 67 countries.[47] For example, in Bangladesh, MISP training was integrated in the IPPF SPRINT (sexual and reproductive health in crisis and post-crisis situations) programme.[48] In Nepal, MISP trainings were institutionalised and managed by national ministries.[49] The country programme evaluation for Papua New Guinea noted that two trainings for 60 health managers in two provinces were insufficient for building a sustainable national programme for emergency reproductive health services in humanitarian settings, and suggested that a central rapid response team would have been more cost-effective.[50] According to UNFPA staff interviews, in the wake of hurricane Matthew in 2016, the UNFPA Haiti country office scaled up MISP trainings and engaged more with national- and sub-national level institutions.

Interviews and surveys suggested good experience with contextualized and local language MISP trainings and capacity building materials. The problem of rapid turnover of trained personnel remains, which threatens the sustainability of results.

Another MISP minimum requirement is to ensure that clinical care is available for survivors of sexual violence in emergency situations, and UNFPA is considered to undertake very important work enabling clinical management of rape. However, responding to the needs of survivors of sexual violence can be very difficult. Challenges include developing the appropriate messages; a lack of detection mechanisms; lack of clinical protocols and curricula/trained health professionals; insufficient geographical reach; and denial, sensitivities, stigma and cultural stereotypes. Some examples of good practice in the clinical management of rape were identified, however. Humanitarian interventions on behalf of Rohingya refugees in Bangladesh included clinical management of rape survivors.[51] In Somalia, UNFPA facilitated the development and roll-out of a comprehensive manual on clinical management of rape survivors and clinical management of rape guidelines.[52] In 2014, UNFPA supported referral pathways and clinical management of rape training in Sudan for 422 midwives, medical assistants, social workers and doctors. Acquired skills were put to use in internally displaced person camps in South Darfur.[53] Interviews implied that the Libya country office is piloting the integration of clinical management of rape and psycho-social support with sexual and reproductive health services to reduce stigma.

Within the Inter-Agency Working Group on Reproductive Health in Crises, UNFPA is in charge of assembling and delivering emergency reproductive health kits as part of the MISP.[54] In 2015, over 8,000 reproductive health kits were delivered to assure the provision of sexual and reproductive health services;[55] in 2016, over 13,043 were delivered across 48 countries[56]. Some

47 2017 progress report, paragraphs 23, 26 and 41.
48 Independent Country Programme Evaluation: Bangladesh 2012-2016.
49 UNFPA Country Programme Evaluation: Nepal 2013-16.
50 UNFPA Country Programme Evaluation: Papua New Guinea 2012-2017.
51 Independent Country Programme Evaluation: Bangladesh 2012-2016.
52 Independent Country Programme Evaluation: Somalia 2011-2015.
53 UNFPA Country Programme Evaluation: Sudan, Final Evaluation Report, 6th Cycle Programme 2013-2016.
54 Inter-agency Field Manual on Reproductive Health in Humanitarian Settings, 2010, p. 44.
55 2016 progress report, annex 5.
56 2017 progress report, annex 4.

examples of good practice were identified. In Lebanon, UNFPA supported the distribution of reproductive health kits to health facilities with high attendance of Syrian refugees.[57] In Liberia, during the Ebola virus outbreak, UNFPA provided reproductive health kits and other supplies to one-stop centres, which led to increased confidence of clients and health workers.[58] In Somalia, delivery kits were provided to maternity waiting homes located in displacement settlements along with equipment and funding for staff salaries; post-rape kits were positioned at referral points and major hospitals.[59] While the coverage of emergency reproductive health kits has increased, UNFPA faces particular logistical challenges (4.7.4).

External views

External stakeholders consulted as part of this meta-analysis were overwhelmingly of the opinion that UNFPA has sufficiently prioritized the MISP. Asked how UNFPA could further increase its contribution to meeting basic sexual and reproductive health needs through the MISP, responses can be categorised as follows:

- Greater coverage of sexual and reproductive health and reproductive rights needs in crisis situations
- More pre-positioning of relief items
- Increase reliability and adequacy of UNFPA staff capacities and skills across the globe
- Importance of surveying humanitarian needs and monitoring use and uptake
- Advocacy and awareness-raising
- Capacity building
- Substitution/direct implementation when authorities/partners are unable to act
- Better communication and coordination with partners.

Facilitating/constraining factors

Overall, information gathered highlights several factors that have facilitated and/or constrained the promotion and implementation of MISP in highly vulnerable contexts:

- **Government ownership.** MISP inclusion and implementation has benefited from good relations with government authorities and strong government support. In other instances, it has suffered from small national health budgets and implementation/coordination capacities, changing governments and rapid personnel turnover, for example, in countries of the Asia and Pacific region.
- **Funding and human resources.** Insufficient funding and staff shortages have negatively affected the ability of UNFPA to prioritize the MISP. Adequate country office staff capacities and expertise are a precondition. The ability to undertake upstream work is a central aspect of UNFPA engagement to improve preparedness and increase resilience. The physical presence of sexual and reproductive health and reproductive rights staff at the sub-national level—such as in drought-affected areas in Ethiopia—benefits the performance of UNFPA considerably. Strong implementing partners can help fill capacity gaps.
- **Coordination and leadership.** UNFPA leadership of sexual and reproductive health sub-clusters/working groups where they exist increases priority setting (see paragraph 4.5 for a more in-depth analysis).
- **Cultural sensitivities.** As seen in countries including Libya, Nigeria, Pakistan and Yemen, stigma and cultural conservatism/sensitivities or denial—around, for example, sexual violence, the needs and preferences of (unmarried) adolescents and youth or HIV—have constrained MISP inclusion and implementation.
- **Procurement and pre-positioning.** The ability of UNFPA to procure, pre-position and provide humanitarian commodities impacts preparedness and response (see paragraph 4.7 for a more in-depth analysis). Active anticipation of, and preparations for, recurring/seasonal crisis situations—for example, hurricanes in Latin America or elections in Western and Central Africa—have provided good results.
- **Physical access to beneficiaries.** Difficult access to target groups and survivors due to climatic conditions[60], highly-contagious epidemic-related diseases[61], geographical topography, continuous relocation of refugee camps[62], or fragile security situation all need to be factored in.

57 Independent Country Programme Evaluation: Lebanon 2010–2014.
58 Independent Country Programme Evaluation: Liberia 2013-2017.
59 Independent Country Programme Evaluation: Somalia 2011-2015.
60 UNFPA Country Programme Evaluation: Sudan, Final Evaluation Report, 6th Cycle Programme 2013-2016.
61 Evaluation indépendante du 7è programme de pays UNFPA/Guinée, Rapport Final, Août 2016.
62 UNFPA Country Programme Evaluation: Sudan, Final Evaluation Report, 6th Cycle Programme 2013-2016.

4.2 Gender-based violence

To what extent are UNFPA country offices in a position to support countries experiencing highly vulnerable contexts to put in place gender-based violence protection mechanisms that prevent and respond to gender-based violence from the onset of an emergency?

SUMMARY:

UNFPA country offices have sufficiently prioritized gender-based violence in emergencies; engagement has been facilitated by the formal designation of UNFPA as lead of the area of responsibility for gender-based violence. UNFPA country offices have been working towards incorporating standards and interventions for gender-based violence in contingency and response plans. They have engaged to improve gender-based violence information management in humanitarian contexts, including through the Gender-based Violence Information Management System (GBVIMS). They have distributed dignity kits to affected women and girls. Experience with dignity kits has differed and challenges have mainly pertained to procurement, contents and distribution. Pre-positioning has been found to cut delivery time and raise visibility. As for socio-economic empowerment of women and girl survivors, some concerns were voiced that UNFPA has not sufficiently followed up and reintegrated survivors once an acute emergency situation had passed. Some concerns were also voiced over lack of corporate guidance. In quite a few instances, there was poor international awareness or recognition of gender-based violence as a humanitarian issue and gender-based violence came second to more visible needs. Sensitivities and stigma around gender-based violence have also posed challenges. Lessons learned are: that systematically pursuing synergies with sexual and reproductive health in emergencies is beneficial; that establishing working relations with strong local partners is crucial; and that emergencies can increase the willingness of decision-makers to tackle gender-based violence in the long-term. UNFPA country offices have not always had the necessary budgets and expertise at their disposal for tasks such as preparedness work and engaging in advocacy and policy dialogue.

The UNFPA gender-based violence in emergencies (GBViE) standards were published in December 2015. They comprise a set of 18 interconnected standards for humanitarian contexts and crisis preparedness efforts that draw upon the comparative advantage of UNFPA and its global expertise and are based on international best practice. The standards are grouped in three parts: (i) foundational standards; (ii) mitigation, prevention and response standards; and (iii) coordination and operational standards (Figure 2). While the standards apply in all settings (preparedness, response, recovery), all actions may not apply to all settings or to all stages of an emergency.[63]

Output 11 of the UNFPA Strategic Plan 2018-2021 commits UNFPA to increasing multi-sectoral capacity to prevent and address gender-based violence using a continuum approach in all contexts, with a focus on advocacy, data, health and health systems, psychosocial support and coordination. Going beyond output 10 of the UNFPA Strategic Plan 2014-2017,[64] indicator 11.4 of the UNFPA Strategic Plan 2018-2021 specifically anticipates an increase in the number of UNFPA programme countries that have applied the minimum standards for the prevention of, and response to, gender-based violence in emergencies.

Going into details for each minimum standard is beyond the scope of this meta-analysis. The following paragraphs synthesize information offered by interviewees and survey participants. In quite a few instances, it appears that there is poor international awareness and recognition of gender-based violence as a humanitarian issue and it has come second to more visible challenges such as cholera and famine. Despite such difficulties, overall, staff interviewees and survey participants felt that UNFPA country offices were sufficiently prioritizing gender-based violence in emergencies. With the universal 2030 Agenda for Sustainable Development, a new challenge has surfaced—notably, how to engage in fragile contexts in developed countries such as Italy and Greece, for example—in connection with the refugee crisis.

63 UNFPA Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies (2015).

64 Output 10: Increased capacity to prevent gender-based violence and harmful practices and enable the delivery of multi-sectoral services, including in humanitarian settings.

FIGURE 2:
Gender-based violence in emergencies standards

Minimum Standards for Prevention and Response to GBV in Emergencies

1 Foundation Standards

1. Participation: Communities, including women and girls, must be engaged as active partners to end GBV and to promote survivors' access tos ervices.

2. National Systems: actions to prevent, mitigate and respon to GBV in emergencies strengthen antional systems and build local capcities.

3. Positive Gender & Social Norms: Preparedness, prevention and response programming promotes positive social and gender norms to address GBV.

4. Collecting & Using Data: Quality, disaggregated, gender sensitive data on the nature and scope of GBV and on the availability and accessibility of services informs programming decisions, policy dialogue and advocacy.

2 Mitigation, Prevention & Response Standards

5. Healthcare: GBV survivors, including women, men, girls and boys, access quality, life-saving healthcare services, specifically clinical management of rape (CMR).

6. Mental Health & Psycosocial Support: GBV survivors have safe access to quality mental health and psychosocial support focused on healing, empowerment and recovery.

7. Safety & Security: Safety and security measures are in place to prevent and mitigate gender based violence and protect survivors.

8. Dignity Kits: Culturally relevant dignity kits distributed to affected populations to reduce vulnerability and connect women and girls to information and support services.

9. Justice & Legal Aid: The legal and justice sectors protect survivors' rights and support their access to justice consitent with international standrads.

10. Socio-Economic Empowerment: Women and adolescent girls access livelihood support to mitigate the risk of GBV, and survivors access Socio-economic support as part of multi-sector response.

11. Referral Systems: Referral systems are established to connect women, girls and other at-risk groups to appropriate multi-sector GBV prevention and response services in a timely and safe manner.

12. Mainstreaming: GBV risk mitigation and survivor support are integrated accross humanitarian sectors at every stage of the programme cycle and throughout the emergencey response.

3 Coordination and Operational Standards

13. Preparedness & Assesssment: Potential GBV risks and vulnerable groups are identified through quality gender sensitive assessments and risk mitigation measures are put in place before the onset of an emergency.

14. Coordination: Coordination results in effective action to protect women and girls, boys and men, mitigate and preventgender-based violence, and promote survivors' access to multi-sector services.

15. advocacy & Communication: Coordinated advocacy and communication leads to increased funding and changes in policies and practice that mitigate the risk of GBV, promote resilience of women and girls, and encourage a protective environment fro all.

16. Monitoring & Evaluation: Objective information collected ethically and safely, is used to improve the quality and accountability of GBV programs.

17. Human Resources: Qualified, competent, skilled staff are rapidly recruited and deployed to design, coordinate and/or implement programmes to prevent and respond to GBV in emergencies.

18. Resource Mobilization: Dedicated financial resources are mobilized in a timely manner to prevent, mitogate and respond to GBV in emergencies.

Source: UNFPA

Application of gender-based violence in emergencies minimum standards:

Minimum standard 2—GBViE integration in national systems: Similar to interventions on sexual and reproductive health and reproductive rights, UNFPA country offices have been working towards incorporating gender-based violence protection interventions and the minimum standards in contingency and response plans and other relevant documents. For example, in Bangladesh, UNFPA achieved better coverage of gender-based violence in the national and IASC contingency plans as well as the IASC Joint Assessment of the 2014 floods;[65] in Nepal, after the devastating earthquake, UNFPA ensured coverage of gender-based violence in the post-disaster needs-assessment, which fed into the government's post-disaster relief framework. Moreover, more and more districts put a stronger emphasis on gender-based violence in their district disaster-preparedness plans.[66]

Minimum standard 4—collecting and using gender-based violence data: The unavailability of reliable and representative (real-time) data impedes effective preparedness and response. UNFPA is committed to engaging with other stakeholders to improve gender-based violence information management mechanisms, support national systems and promote a culture that goes beyond collection and documentation of gender-based violence incidents. UNFPA is particularly committed to coordinating the globally-endorsed Gender-Based Violence Information Management System (GBVIMS) for safe and ethical data collection, storage and sharing, particularly in humanitarian contexts.[67] For example, in

65 Independent Country Programme Evaluation: Bangladesh 2012-2016.
66 UNFPA Country Programme Evaluation: Nepal 2013-16.
67 2017 progress report, annex 4. For further information about GBVIMS, see http://www.gbvims.com/.

Somalia, UNFPA was the lead agency on GBVIMS and chaired the information management system task force. It trained stakeholders on data collection techniques, harmonization of data-collection tools and utilization of the information management system. It also supported the development of a user guide. Partners were using the reporting system monthly both at zonal and national levels.[68] In DRC, UNFPA supported the ministry of gender to establish a national gender-based violence data-collection system and standard operating procedures. It also provided trainings on gender-based violence monitoring. In Yemen, UNFPA is collecting and analysing information from partners and feeding data into the Yemen dashboard on gender-based violence.

Minimum standard 8—dignity kits: UNFPA is committed to distributing culturally-relevant dignity kits to affected populations to reduce vulnerability and connect women and girls to information and support services.[69] In 2013, it published dignity kit programming guidelines[70] in response to an evaluation in 2010 of the provision of dignity kits by UNFPA in humanitarian and post-crisis settings. According to these guidelines, the approach of UNFPA is to prioritize the development of country-specific dignity kits: that primarily target women and adolescent girls; that are procured and assembled locally; that are customized to meet the hygiene needs of affected populations; and whose contents are selected in consultation with local communities. It does so in coordination with other humanitarian organizations. At the individual-level, dignity kits allow women and girls to live in dignity during humanitarian crises. At programme-level, they serve as an entry point for broader programming from UNFPA on sexual and reproductive health and reproductive rights, gender-based violence, HIV prevention and psychosocial support. At the institutional-level, they affirm the place that UNFPA holds as a critical humanitarian actor.

UNFPA has supplied dignity kits in numerous circumstances, including in response to the European refugee crisis.[71] UNFPA experience with dignity kits has differed: challenges mainly pertained to procurement, contents and distribution. Pre-positioning has been found to cut delivery time and raise visibility. Some examples of good practice were identified: supplying dignity kits was found to be one of the added values of UNFPA in Burundi;[72] in Nepal, supplies helped strengthen the status and voice of the comparatively underfunded, understaffed and under-prioritized ministry responsible for the response to gender-based violence;[73] in Yemen, while national security authorities questioned the contents of UNFPA dignity kits, they were very well received at community level and provided visibility for UNFPA.[74] On the other hand, in Lebanon, the heterogeneity of the needs of the refugee population was found to be insufficiently reflected in the design and content of dignity kits.[75]

Minimum standard 10—socio-economic empowerment: Minimum standard 10 requires women and adolescent girls to have access to livelihood support to mitigate the risk of gender-based violence, and survivors to have access to socio-economic support as part of a multi-sector and nexus approach. For example, in Yemen, the country office has partnered with the British Council "Springboard–Women's Development Programme" to help women to release their potential and achieve success in their personal and professional lives;[76] and in Myanmar, UNFPA response has included literacy lessons, sewing machines and women's participation activities, depending on the context. Some concerns were voiced that UNFPA did not sufficiently follow up and reintegrate survivors once an initial emergency response was over. Reasons provided were lack of corporate guidance, but also insufficient funding.

Minimum standard 15—advocacy and communication: Advocacy and communication raises community awareness of available services. For example: in Bangladesh, UNFPA-supported community watch groups worked to increase awareness of gender-based violence and available services in Rohingya refugee camps; and the Yemen country office, as the chair of the gender-based violence sub-cluster, initiated the creation of a communication working group to define and distribute locally-relevant communication and advocacy messages.

External views

External stakeholders consulted as part of this meta-analysis were overwhelmingly of the opinion that UNFPA has sufficiently prioritized GBViE. Asked how UNFPA could further increase its contribution to preventing and responding to gender-based violence in emergencies, responses can be categorised as follows:

68 Independent Country Programme Evaluation: Somalia 2011-2015.
69 UNFPA Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies (2015).
70 UNFPA Dignity Kit Programming Guidelines (2013).
71 2016 progress report, annex 5.
72 Evaluation finale du 7ème programme de coopération Burundi, UNFPA 2010-2015, Septembre 2016.
73 UNFPA Country Programme Evaluation: Nepal 2013-2016.
74 2016 progress report, annex 5.
75 Independent Country Programme Evaluation: Lebanon 2010–2014, Evaluation Office, New York, June 2014.
76 https://yemen.britishcouncil.org/en/partnerships/success-stories/springboard.

- Better contextualize GBViE work
- Ensure greater coverage of gender-based violence survivors
- Advocacy and awareness raising/sensitization
- More support for detecting, referring and monitoring gender-based violence cases
- Safe houses, one-stop crisis management centres, shelters, counselling centres etc.
- Enable substitution/direct implementation when authorities/partners are unable to act
- Increase pre-positioning of dignity kits
- More financial resources
- Improve reliability and adequacy of UNFPA staff capacities and skills across the globe
- Ensure availability of strong implementing partners

Facilitating/constraining factors

Overall, information gathered highlights several factors that have facilitated and/or constrained the promotion and implementation of the GBViE minimum standards in highly vulnerable contexts. They reflect very similar experiences as with sexual and reproductive health and reproductive rights and the MISP. They are:

- **Government ownership.** In a number of countries, UNFPA has benefited from strong government support for the prevention of and response to gender-based violence. In others, it has faced challenging relationships, a lack of commitment, and a total breakdown of national systems to capacitate or with which it could partner. Emergencies can open doors and increase the willingness of decision-makers to commit to tackling gender-based violence in the long-term, an important lesson for UNFPA work across the nexus.
- **Funding and human resources.** Fulfilling the UNFPA mandate in highly vulnerable contexts requires making available a sufficiently large budget and the necessary country office expertise in GBViE programming, especially for preparedness work as part of regular programming.[77] These resources are not always in place. Policy dialogue and advocacy are particularly important modes of engagement for promoting the GBViE minimum standards, which requires the necessary competences.
- **Coordination and leadership.** The formal designation of UNFPA as the lead of the gender-based violence area of responsibility is an advantage for the Fund's ability to engage (see paragraph 4.5 for a more in-depth analysis).
- **Local partners.** It is important for UNFPA to identify strong, local, non-governmental partners as part of its preparedness activities, such as the Yemeni Women's Union, and those with sub-national presence. The complete absence of, or limited capacities of, local organizations—to provide, for example, legal assistance and counselling—is an important hindrance.[78]
- **Synergies with sexual and reproductive health and reproductive rights.** It was widely suggested that systematically clustering and pursuing synergies with sexual and reproductive health and reproductive rights in emergencies was beneficial. The lack of coordination between health and protection actors—for rapid deployment of trained professionals to emergency sites, for example—has been a constraining factor.
- **Awareness and cultural sensitivities.** Sensitivities and stigma, as well as a lack of community awareness, around gender-based violence and fear of social pressure and exclusion have considerably affected UNFPA GBViE programming.[79] Experience in other contexts shows that being sensitive to the local cultural context and engaging with traditional/religious leaders has benefited GBViE programming.
- **Physical access to beneficiaries.** As in the case of sexual and reproductive health and reproductive rights programming, the geographical topography—for example in Nepal—and safety and security challenges—for example, in Nigeria, Somalia,[80] Sudan[81] and Yemen—have rendered GBViE programming challenging.
- **Procurement and pre-positioning.** The ability of UNFPA to procure, pre-position and provide humanitarian commodities impacts preparedness and response (see paragraph 4.7 for a more in-depth analysis). Active anticipation of, and preparations for, recurring/seasonal crisis situations—linked to hurricanes or elections, for example—have provided good results.

77 *Inter alia,* Lessons learned, p. 22.
78 Evaluation indépendante du 6ème programme de pays Tchad 2012-2016, février 2016.
79 *Inter alia,* Lessons learned.
80 Independent Country Programme Evaluation: Somalia 2011-2015.
81 UNFPA Country Programme Evaluation: Sudan, Final Evaluation Report, 6th Cycle Programme 2013-2016.

4.3 Data for emergency preparedness and response

To what extent are UNFPA country offices in a position to support countries experiencing highly vulnerable contexts to ensure greater availability and use of disaggregated data for humanitarian programming?

SUMMARY:

UNFPA has supported programme countries in data collection and analysis with a view to strengthening capacities for better preparedness, recovery and needs assessments at the onset of emergencies. UNFPA has generated data for humanitarian programming with the help of population censuses and sample household surveys. It has experimented with geo-referencing. Its involvement in needs assessments has increased. However, in most countries this area of work is not as advanced as its work in sexual and reproductive health, reproductive rights and gender-based violence. Across the globe, UNFPA is not the "go-to" agency in data collection and is not playing a leading role in data collection and analysis. Political instability and weak national systems have hindered the ability of UNFPA to engage. Low levels of funding, insufficient human resources and missed opportunities to engage population and development officers in humanitarian programming have also hindered UNFPA engagement. Corporate guidance and tools for operationalizing UNFPA commitment are inadequate.

Data issues cut across all activities in all humanitarian crisis phases. Each humanitarian cluster relies on specific types of data or information for resource mobilization, decisions on actions to be taken, or measuring impact. According to its standard operating procedures for humanitarian settings, UNFPA is committed to strengthening national capacity for improved availability of, and access to, data in the development of its humanitarian response frameworks and transition and recovery plans. This includes access to reliable population and housing census data and demographic and health survey data that is vital for disaster preparedness. UNFPA also plays a key role in improving data collection, analysis and utilization before, during and after humanitarian emergencies; and improving coordination in programme and policy planning by government and relevant humanitarian and development partners.

UNFPA has supported programme countries in data collection and analysis with a view to strengthening capacities for better preparedness, recovery and needs assessments at the onset of emergencies. However, in most countries this area is not as advanced as those in sexual and reproductive health, reproductive rights and gender-based violence. There are good examples, but according to interviewees it is work in progress. The 2010 UNFPA Guidelines for Data Issues in Humanitarian Crisis Situations[82] seem to have been insufficiently mainstreamed within the organization. UNFPA appears to be one humanitarian data agency among others to contribute to data for humanitarian programming. Across the globe, it is not the "go-to" agency for this area and is not playing a leading role. Survey responses confirmed this impression, particularly regarding data for better preparedness.

The UNFPA Strategic Plan 2018-2021 has raised expectations regarding the role of UNFPA in ensuring greater availability and use of disaggregated data for humanitarian programming.[83] Annex 4 of the strategic plan commits UNFPA to increasing its investments in data in emergencies.[84] Also, while the UNFPA Strategic Plan 2014-2017 emphasized support for data collection and analyses during acute emergency phases,[85] the UNFPA Strategic Plan 2018-2021 integrated results and resources framework covers both preparedness and response. It defines concrete expected outputs—such as common operational data sets on population statistics (indicator 13.5), sub-national mappings (indicator 14.4) and rapid assessments (indicator 13.4).

Data for humanitarian programming

UNFPA generated data for humanitarian programming, including for recovery and transition, with the help of population censuses. The evaluation of UNFPA support to population and housing census data 2005-2014 found that available regular resources had been strategically directed to data generation for humanitarian programming. Good examples are cited among some programme countries at risk: Sudan (joint Sudan and South Sudan census as part of the peace agreement);

82 UNFPA Guidelines on Data Issues in Humanitarian Crisis Situations (2010).
83 *Inter alia,* UNFPA SP 2018-2021, annex 4, paragraph 38.
84 UNFPA SP 2018-2021, annex 4, paragraph 38.
85 Proportion of countries experiencing a humanitarian crisis situation in which UNFPA provided technical assistance on the use of population-related data and support for assessments (Outcome 4, Output 12, Indicator 12.1).

Myanmar (request for support after more than 30 years without a census); Kenya (post-conflict situation); and Mauritania (post-coup country). Staff interviews revealed that UNFPA recently mobilized $30 million for a census in Haiti, the first since 2003. Two examples suggest that UNFPA is well positioned to coordinate between national statistics offices and national disaster management authorities: in Indonesia, UNFPA supported the integration of population census data into the Indonesian Disaster Information and Data System in order to map out populations vulnerable to disasters;[86] in Myanmar, 2014 census data informed the humanitarian response plan and in 2015 was used for the OCHA-led flood appeal and for validating the reliability of locally received data on population needs.

Sample household surveys are another vehicle for making available humanitarian data. For example, in the Democratic People's Republic of Korea (DPRK), the UNFPA-supported Socio-Economic, Demographic and Health Survey was expected to provide representative data at the provincial as well as county level for development programming and programming in case of emergencies;[87] in Somalia, UNFPA led the Population Estimation Survey of Somalia (PESS) to provide evidence-based, technically sound and reliable population estimates, including for internally displaced persons and nomads. The PESS enabled the federal government to develop a two-year development plan based on the data.[88]

Furthermore, UNFPA is experimenting with geo-referenced data. For instance, the UNFPA Latin America and Caribbean Regional Office (LACRO) developed a mobile-ready web-based and geo-referenced application for use in humanitarian situations.[89] In Libya, UNFPA is partnering with UN Habitat as well as national authorities and municipalities to implement the programme "Rapid City Profiling and Monitoring System for Libya". The programme aims to increase the level of understanding regarding the impact of the ongoing crisis in urban areas and provide geo-based data to support the response and early recovery aid from the humanitarian and development community.[90]

Needs assessments

As mentioned above, indicator 12.1 of the UNFPA Strategic Plan 2014-2017 expected an increase in the proportion of countries experiencing a humanitarian crisis situation in which UNFPA provided technical assistance on the use of population-related data and support for assessments. Indicator 13.4 of the UNFPA Strategic Plan 2018-2021 expects the proportion of countries experiencing humanitarian crises that conduct rapid assessments of the affected populations, including pregnant women, to increase.

UNFPA data reveal an increase in support for assessments. In 69 per cent of countries experiencing a humanitarian crisis in 2014, UNFPA provided technical assistance on the use of population-related data for needs assessments.[91] In 2015, it was 73 per cent[92] and in 2016, 77 per cent.[93] For example, in the three countries affected by the Ebola outbreak, UNFPA mobilized over 8,000 Ebola contact tracers, who monitored more than 90,000 contacts to prevent further transmission.[94] In Liberia, collecting real time data helped break the transmission of the Ebola virus and provided a basis for putting in place stronger surveillance infrastructure for future crises.[95] In Nepal, UNFPA contributions to the post-disaster needs assessment influenced the post-disaster relief framework and earthquake response. Inter alia, UNFPA mobilized youth to collect primary data.[96] Staff interviews indicated that in Haiti UNFPA was able to include pregnant women in the OCHA-led Multi-Cluster/Sector Initial Rapid Assessment (MIRA) following hurricane Matthew.

UNFPA deployed staff to contribute to rapid needs assessments. For instance, staff interviews indicated that, in Haiti, UNFPA joined the first surveillance mission after hurricane Irma in 2017. In Myanmar, the UNFPA population and development team was called upon for support during the floods in 2015 and 2016 and subsequent planning. In Nepal, the country office offered gender-based violence/gender experts to all humanitarian clusters to ensure a gender perspective to the earthquake response and to communicate with affected women.

86 *Inter alia,* Evaluation of UNFPA support to population and housing census data 2005-2014, pp. 46 and 55.
87 UNFPA Country Programme Evaluation: the Democratic People's Republic of Korea Fifth Programme Cycle, 2011-2015/6.
88 Independent Country Programme Evaluation: Somalia 2011-2015.
89 2016 Progress Report, annex 5; https://www.globalinnovationexchange.org/innovations/geo-referenced-app-humanitarian-situations.
90 https://unsmil.unmissions.org/workshop-rapid-city-profiling-and-monitoring-system-libya.
91 2015 progress report, table 1.
92 2016 progress report, paragraph 44.
93 2017 progress report, paragraph 62.
94 2015 progress report, paragraph 13. As member of the Global Ebola Response Coalition and with its response integrated into the United Nations Mission for Emergency Ebola Response.
95 Independent Country Programme Evaluation: Liberia 2013-2017.
96 UNFPA Country Programme Evaluation: Nepal 2013-2016.

External views

The majority of external stakeholders consulted as part of this meta-analysis were of the opinion that UNFPA is a credible partner for the production of population statistics and vulnerability mappings, and that the Fund has been sufficiently involved in rapid assessments. Interviewees agreed that UNFPA was less strong in this area than in the areas of sexual and reproductive health, reproductive rights and gender-based violence. Asked about possible measures for further increasing its contribution to better data for humanitarian programming, responses can be categorised as follows:

- Support for data collection and analysis guidance, methodologies and tools
- Support for databases and information management systems
- Training and capacity building for data collection, assessment and management
- Support for surveys, assessments, studies
- Information dissemination

Facilitating/constraining factors

Overall, information gathered highlights several factors that have facilitated and/or constrained the ability of UNFPA to support greater availability and use of disaggregated data for humanitarian programming:

- **Political instability and national ownership**. The ability of UNFPA to engage in the area of humanitarian data has suffered where national/government systems for data collection and analysis are missing or non-functioning—for example, in Haiti where the election process took two years and the transition government was heavily contested—and in situations where governments are reluctant to maintain transparent and accessible data systems. It has profited where governments and its partners also prioritized sexual and reproductive health, reproductive rights and gender-based violence. At the international level, sexual and reproductive health and reproductive rights issues need to be better reflected in global rapid assessment tools—for example, the Multi-Cluster/Sector Initial Rapid Assessment (MIRA).
- **Mandate.** In some instances, UNFPA has faced little international recognition of, and respect for, its mandate as a humanitarian data agency, even from within the United Nations system. This was attributed to little visibility, the small scale of support provided at country level and competition amongst agencies for scarce funding. As a result, it has on occasion not been invited to participate in rapid assessments.
- **Funding and human resources.** In some places, weak population and development resources and low prioritization have limited UNFPA involvement. Insufficient human resources at country level have been aggravated by a long-term vacancy at UNFPA headquarters. It was questioned why no population and development officers acted as country office humanitarian focal points and why UNFPA data specialists/statisticians did not participate in rapid assessments. Moreover, insufficient internal cooperation between humanitarian focal points, monitoring and evaluation officers and population and development officers was noted. On the positive side, humanitarian data gathering and use has benefited in instances from UNFPA presence at the sub-national level, including through the Fund's implementing partners, such as in Afghanistan and Liberia.
- **Cooperation.** Close cooperation with humanitarian agencies[97] and other data-gathering and research organizations has facilitated UNFPA work. In particular, partnering with OCHA around the setting up and updating of the common operational dataset[98] population statistics has been very helpful. Equally helpful has been active participation in developing joint needs assessment tools in order to ensure inclusion of data on gender-based violence and sexual and reproductive health.
- **Accessibility and timeliness of data.** Limited access to affected areas and population groups renders data collection difficult, generally, because of safety and security issues. Gathering real-time data is a challenge. Rapidly changing volatile contexts—for example, numbers of people on the move in Somalia, with continuously changing datasets—are also hard to keep up with.
- **Corporate guidance.** According to some interviewees, technical guidelines and tangible tools for capacitating UNFPA country offices and operationalizing UNFPA commitment to population and development data in humanitarian settings are inadequate.

97 For instance, UNHCR.
98 https://www.humanitarianresponse.info/en/applications/tools/category/operational-datasets.

4.4 Humanitarian-development nexus

To what extent are UNFPA country offices in a position to use a continuum of interventions interlinking humanitarian, transition and development programming?

SUMMARY:

As an organization providing development cooperation and humanitarian assistance, UNFPA has committed itself to the "new way of working" and participates in various global multi-stakeholder working groups and initiatives. In 2017, the UNFPA Executive Board commended the Fund for its invaluable work to bridge the humanitarian-development divide. Staff interviews and survey responses suggested similar understandings of the relevance of mutually inter-linking humanitarian assistance and development work for the benefit of vulnerable societies and communities to prepare for, survive and recover from shocks. The interviews and survey responses also acknowledged the disadvantages of development and humanitarian actors working in silos. Working across the nexus has consequences for UNFPA alignment with country-level strategic frameworks, programme focus, modes of engagement, choice of implementing partners, geographical coverage and operations. In places, insufficient awareness of an absent but important corporate position, resource gaps and separate structures and mechanisms were perceived as barriers to operating across different forms of aid. (Re-)introducing comprehensive reproductive health services appears to be a particularly complex challenge.

The UNFPA Strategic Plan 2014-2017 expanded the UNFPA mandate and commitment as a humanitarian actor. The mid-term review of this strategic plan talks about the importance of carrying emergency programming forward into regular programming and transitioning to more comprehensive services.[99] The evaluation of the UNFPA Strategic Plan 2014-2017 architecture made a similar recommendation—that was, to ensure that guidance for operationalizing the UNFPA Strategic Plan 2018-2021 links humanitarian and development programming and makes the implications of countries shifting into or out of a humanitarian context.[100] Looking ahead, the UNFPA Strategic Plan 2018-2021 emphasizes the Fund's commitment to strengthening complementarity among its humanitarian and development activities. "To begin alignment of the strategic plan to the 2030 Agenda, …, the strategic plan has adopted the key principles of the 2030 Agenda, including: … (c) strengthening cooperation and complementarity among development, humanitarian action and sustaining peace; …".[101]

UNFPA has committed itself to the "new way of working".[102] Different inter-agency bodies address the humanitarian-development nexus: The United Nations Working Group on Transitions was originally established in 2006 as the UNDG-ECHA Working Group on Transition. As a standing body within the United Nations Development Group (UNDG) architecture, it provides a forum for consultation and information sharing and provides policy guidance and supports advocacy.[103] At the World Humanitarian Summit in 2016, "the largest number of stakeholders … identified the need to strengthen the humanitarian-development nexus and to overcome long-standing attitudinal, institutional, and funding obstacles. While nothing should undermine the commitment to principled humanitarian action, especially in situations of armed conflict, there is, at the same time, a shared moral imperative of preventing crises and sustainably reducing people's levels of humanitarian need, a task that requires the pursuit of collective outcomes across silos". A collective outcome was defined as "the quantifiable and measurable result that development, humanitarian and other relevant actors want to achieve over a multi-year period of 3-5 years" within the context of the Sustainable Development Goals (SDGs).[104] At the summit, the United Nations Secretary-General and eight United Nations heads, including UNFPA, signed a "Commitment to Action", in which they agreed to put in place a new way of working in crises that aims to not only meet humanitarian needs but also to reduce them over time.[105] After the summit, the United Nations Secretary-General established the Joint Steering Committee to Advance Humanitarian and Development Collaboration under the leadership of the Deputy Secretary-General to guide the new way of working. UNFPA requested inclusion in the steering committee, but this has not yet been

99 2016 progress report, annex 5.
100 Recommendation 6.
101 UNFPA SP 2018-2021, paragraph 8.
102 UNFPA has committed itself to the "new way of working" as described in the Commitment to Action, signed by the Secretary-General and eight United Nations principals at the World Humanitarian Summit. This commitment frames the work of development and humanitarian actors, along with national and local counterparts, in support of collective outcomes towards the achievement of the Sustainable Development Goals
103 https://undg.org/wp-content/uploads/2016/08/UN-Working-Group-on-Transitions-TORs-5Dec2014.pdf.
104 OCHA: New Way of Working, 2017.
105 https://www.iom.int/news/un-launches-commitment-action-whs-moving-delivering-aid-ending-need.

approved. Furthermore, The IASC Task Team on Strengthening the humanitarian and development nexus with a focus on protracted crises was established, co-chaired by UNDP and WHO and open to all IASC members.[106] UNFPA has participated. However, in 2017, the task team produced a draft humanitarian-development nexus mapping in which UNFPA did not figure.[107]

Staff interviews and survey responses suggested similar understandings of the relevance of mutually inter-linking humanitarian assistance and development work for vulnerable societies and communities/population groups to prepare for, survive and recover from shocks. The interviews and survey responses also acknowledged the disadvantages of development and humanitarian actors working in silos. Programming across the nexus was considered by interviewees to be critically important, especially in protracted crises and situations of high risk of natural disasters occurring. The programming needs to happen systematically and consistently, with a focus on the most vulnerable. In protracted crisis situations and countries experiencing regular disasters, working across the nexus should be "business as usual" in order to build resilience/reduce vulnerabilities and for societies to recover (faster) and sustainably develop in the long term. Interviewees emphasized that the new way of working had moved away from temporarily shifting from one setting and modus to another and back again in a sequential manner. In protracted crisis situations, communities do not differentiate between development and humanitarian support or funding streams.

As well as having implications for UNFPA operations (for more details, see paragraph 4.7), working across the nexus has consequences for the alignment of UNFPA with country-level strategic frameworks, programme focus, modes of engagement, choice of implementing partners, and geographical coverage. In terms of strategic alignment, the following were highlighted as good examples: the Sudan Multi-Year Humanitarian Strategy 2017-2019,[108] the United Nations Strategic Framework Lebanon 2017-2020,[109] the 2017 Uganda Comprehensive Refugee Response Framework, the Federally Administered Tribal Areas Transition and Recovery Programme in Pakistan, and the Humanitarian Support Initiative for Women and Children Affected by the Boko Haram Crisis. Generally, it was noted that the 2017 UNDAF guidelines emphasised the integration of development, humanitarian and peacebuilding linkages as a programming principle.

In terms of focus, the importance of including MISP and GBViE in contingency plans and health system strategies and regularizing cluster coordination for better response preparedness was frequently emphasized. In terms of modes of engagement, effective engagement requires expert advocacy, policy dialogue and coordination skills, together with the capability to build long-term capacities of institutions ("systems-building") and communities alongside short-term relief (service delivery). In terms of partnerships, a recommendation was made for country offices to identify and, if necessary, train humanitarian partners before a crisis strikes. Working across the nexus benefits from geographical convergence of humanitarian and development programming. Vulnerability—to natural disasters, for example—is therefore a key factor to consider when developing country programmes and selecting programme areas. UNFPA country offices should have the flexibility to reorient resources to other geographical clusters in humanitarian crisis situations; they should be permitted to continue supporting a non-priority geographical area recovering from an acute emergency.

Niche areas

Literature review and interviews established some concrete examples relevant to the 2014-2017 and 2018-2021 strategic plans, where UNFPA has been working across the humanitarian-development nexus.

Rehabilitation of facilities affected during crises: The mid-term review of the UNFPA Strategic Plan 2014-2017 introduced indicator 5.3, which measured the proportion of countries in early recovery stage where reproductive health facilities that had been affected during crisis, were then rehabilitated. For example, after military operations in Gaza, UNFPA supported the recovery of six primary health care centres and six maternity wards by equipping them with supplies and equipment to ensure quality provision of sexual and reproductive health services.[110] In South Sudan, the Juba protection of civilians maternity wards, Walgak Maternity Unit and the reproductive health Minkaman Clinic were rehabilitated.[111] In Sudan, the country office was able to establish and strengthen community-level women centres—for example, in South Darfur—that

106 https://interagencystandingcommittee.org/; https://interagencystandingcommittee.org/system/files/hdn_tt_tor.pdf.
107 https://interagencystandingcommittee.org/system/files/humanitarian-development_nexus_mapping_2017.pdf.
108 https://reliefweb.int/sites/reliefweb.int/files/resources/Sudan_Multi-Year_Humanitarian_Strategy_2017-2019.pdf.
109 https://www.dropbox.com/s/auqfgtn9yhhytvq/UNSF%20Lebanon%202017-2020-034537.pdf?dl=0.
110 2016 progress report, annex 5.
111 Lessons learned, p. 24.

have become safe social spaces for gender-based violence survivors, women and youth groups, and that thus are contributing to the transition from humanitarian support to recovery.[112] In post-Ebola Liberia, UNFPA supported the physical rehabilitation of rural health facilities and the restoration of maternal health services.[113] This indicator is no longer explicitly included in the UNFPA Strategic Plan 2018-2021.

Participation of youth in peace-building processes: Indicator 8.1 of the UNFPA Strategic Plan 2018-2021 expects an increase in the number of countries that have institutional mechanisms for the participation of young people in policy dialogue and programming, including in peace-building processes. This indicator reflects the lead role of both UNFPA and the International Federation of the Red Cross, in realising the promise of the *Compact for Young People in Humanitarian Action*, as well as the Fund's commitment to the Security Council's resolution 2250 (2015) "maintenance of international peace and security".[114] For example, in Guinea, UNFPA engaged with others in a successful peace building fund project to train youth to conduct sensitization campaigns to achieve a culture of peace in light of inter-community conflicts.[115] In Papua New Guinea, youth interventions such as mock youth parliaments in the context of Bougainville peace-building were found to be popular, and several participants have subsequently taken up a political career. But evidence was lacking as to whether and how empowerment had increased political attention for adolescent sexual and reproductive health and was specifically contributing to sexual and reproductive health outcomes.[116]

Comprehensive sexual and reproductive health services: Part of the nexus is planning for comprehensive sexual and reproductive health services and their integration into primary health care as the situation stabilizes through the MISP. (Re-)introducing comprehensive reproductive health services appears to be a big and complex challenge for UNFPA country offices, especially in situations where health service systems and delivery are already poor. There seems to be a particular challenge relating to continued implementation of minimum services in protracted crisis and stabilising situations, including the continued delivery of emergency reproductive health kits.[117] For example, interviews and document review imply that UNFPA has pursued comprehensive planning even in Level 3 emergencies such as in Yemen where, together with UNICEF, the country office mobilized funding from the World Bank for comprehensive sexual and reproductive health. The "Women and Girls First" project in Myanmar is implemented in cooperation with local and international humanitarian and development partners. It focuses on the most vulnerable women and girls in the remote and conflict-affected provinces of Rakhine, Kachin and northern Shan. This joint initiative provides comprehensive reproductive health care along with emergency assistance, including post-rape treatment, as well as counselling and support to survivors of gender-based violence. The DRC country office received funding from the National Reconstruction and Stabilization Plan (STAREC) to implement gender-based violence interventions across the humanitarian-development nexus.

External views

At the first regular session of the Executive Board in 2017, members welcomed UNFPA focus on rapid humanitarian response and resilience building, and commended it for its impressive humanitarian response and its invaluable work bridging the humanitarian-development divide.[118]

The majority of external stakeholders consulted as part of this meta-analysis were of the opinion that UNFPA has paid sufficient attention to the humanitarian-development nexus. Asked about how UNFPA could further strengthen the humanitarian-development nexus within its programming, responses can be categorised as follows:

- Ensure an integrated approach involving headquarter humanitarian and development branches
- Leverage existing working relationships in times of crisis
- Prioritize and scale-up preparedness interventions in country programmes, including at policy level and through pre-positioning
- Increase institutional responsiveness and flexibility when emergencies strike.

112 UNFPA Country Programme Evaluation: Sudan, Final Evaluation Report, 6th Cycle Programme 2013-2016.
113 Independent Country Programme Evaluation: Liberia 2013-2017.
114 UNFPA Humanitarian Action 2017 Overview.
115 Evaluation indépendante du 7è programme de pays UNFPA/Guinée - Rapport Final, Août 2016.
116 UNFPA country programme evaluation: Papua New Guinea 2012-2017.
117 *Inter alia,* November 2017, Evaluation ERH kits.
118 DP/2017/13: Draft report of the first regular session 2017 (30 January to 3 February 2017, New York).

Barriers to working across the nexus

This meta-analysis probed barriers to bridging the humanitarian-development divide, both external and internal to UNFPA. An external barrier often seems to be the lack of awareness, common understanding, willingness and capacities among government counterparts, donors and implementing partners for operating across different forms of aid. A further external barrier is the disconnect between humanitarian aid and development donors and consequent funding gaps—for example, for preparedness work such as pre-positioning[119] or for supporting communities after an acute emergency phase. Other external barriers mentioned are: separate structures and mechanisms within the United Nations system (for example, funding) for development cooperation, humanitarian relief and peace; a level of conflict and insecurity that requires focusing full attention on emergency relief efforts; and the perception that UNFPA is not a humanitarian agency.

Internal barriers relate to mind-sets and time required to raise awareness and bring UNFPA staff on board to rectify the lack of a strong corporate position and inadequate funding and human resources for working across the nexus. Other—less frequently mentioned difficulties—are institutional barriers between UNFPA development cooperation and humanitarian aid divisions in New York and insufficient sub-national presence.

4.5 Coordination and leadership

To what extent are UNFPA country offices in a position to contribute to and lead humanitarian coordination in the areas of gender-based violence, sexual and reproductive health and reproductive rights, especially within the cluster approach?

4.5.2 UNFPA leadership in sexual and reproductive health humanitarian coordination

SUMMARY:

Where there is a sexual and reproductive health sub-cluster or similar mechanism at country level, UNFPA has played a leading role. However, this does not seem to be automatic nor should it be taken for granted. At times, the mere creation of a coordination mechanism was considered a success in itself. The UNFPA guiding role in sexual and reproductive health humanitarian coordination is affected by the fact that there is no sexual and reproductive health area of responsibility within the IASC cluster architecture, which interviewed staff widely regretted. It depends on the extent and level of stakeholder engagement in, and support for, sexual and reproductive health and reproductive rights, which is often less than for classic humanitarian concerns, and the extent of competition from other organizations for assuming a leading role. It also depends on stakeholder trust in the ability of UNFPA to lead, including at sub-national levels and during protracted crises. Future investments in human resources were considered vital for greater prioritization of sexual and reproductive health and reproductive rights as a humanitarian issue as well as better reliability and credibility of the leading role of UNFPA.

At the global level, UNFPA is a full member of the Inter-Agency Standing Committee (IASC), the mechanism for coordinating humanitarian assistance involving United Nations and non-United Nations partners.[120] The IASC has designated clusters, which are groups of humanitarian organizations, in main sectors of humanitarian action ("cluster approach"). A global health cluster exists to support health clusters in countries. UNFPA is one of many members. There is no formal sexual and reproductive health area of responsibility or sub-cluster under the health cluster, which many interviewed staff regretted.

Neither the UNFPA Strategic Plan 2014-2017 nor its mid-term review tracked the leadership of UNFPA in the sexual and reproductive health humanitarian coordination. The UNFPA Strategic Plan 2018-2021 introduced indicator 5.4, which measures the proportion of countries affected by a humanitarian crisis that have a functioning inter-agency sexual and reproductive health coordination body as a result of UNFPA guidance and leadership.

Where there is a sexual and reproductive health sub-cluster or similar mechanism, information gathered

119 *Inter alia,* UNFPA Country Programme Evaluation: Sudan, Final Evaluation Report, 6th Cycle Programme 2013-2016.

120 The IASC was established in 1992 following United Nations General Assembly Resolution 46/182. Resolution 48/57 confirmed that it should be the primary method for inter-agency coordination.

suggested that UNFPA has played a leading role. However, this does not seem to be automatic nor should it be taken for granted. At times the mere creation of a coordination mechanism was considered a success in itself. For example, in Liberia, UNFPA was designated the focal point for the reproductive health thematic area of the United Nations Consolidated Ebola Support Plan.[121] In Myanmar, the establishment of a sexual and reproductive health technical working group under the health cluster was recognized as a major achievement.[122] In Darfur State in Sudan, UNFPA played a major role in leading and supporting meetings of the reproductive health sub-sector and task force to strengthen coordination between governmental, non-governmental and United Nations agencies.[123] In Bangladesh, UNFPA co-led the health cluster together with WHO.[124]

External views

The great majority of external stakeholders consulted as part of this meta-analysis were of the opinion that UNFPA has sufficiently prioritized guidance and leadership for humanitarian coordination in sexual and reproductive health and reproductive rights. Asked about how UNFPA could further strengthen its guidance and leadership in sexual and reproductive health and reproductive rights, responses can be categorized as follows:[125]

- Extend humanitarian coordination to local levels
- Build capacities of responsible government entities
- Facilitate communication between high-level and grassroots stakeholders
- Ensure medium-term availability of qualified and skilled coordination experts for country offices.

Facilitating/constraining factors

Overall, information gathered highlights several factors that have facilitated and/or constrained the guiding and leading role of UNFPA in sexual and reproductive health humanitarian coordination:

- **Global cluster architecture.** Interviewees regret that, contrary to GBViE, sexual and reproductive health sub-clusters are not envisaged by the IASC as part of the cluster architecture. At the country level, the existence, prioritization and delegation of tasks to sexual and reproductive health sub-clusters depend on health cluster leads.
- **UNFPA leadership role.** UNFPA leadership is important for priority setting and resource mobilization. While some trust in the global mandate of UNFPA in sexual and reproductive health and reproductive rights and have not experienced competition among partners for leadership in sexual and reproductive health humanitarian coordination, others perceive growing competition. They are concerned about poor international awareness and recognition of the leading role of UNFPA, and that, looking ahead, UNFPA is not sufficiently well positioned.
- **Stakeholder engagement.** Government and humanitarian agency engagement in sexual and reproductive health and reproductive rights in humanitarian settings is important. However, sexual and reproductive health and reproductive rights often run a poor second in terms of humanitarian priority setting. The number of stakeholders for UNFPA to lead and funds to expend can be very small. The existence of sexual and reproductive health coordination mechanisms and of health clusters in times of stability and peace facilitate stakeholder engagement in sexual and reproductive health and reproductive rights in emergencies. In one country, UNFPA found that including sexual and reproductive health and reproductive rights in the health cluster (rather than having a separate sub-cluster) reached more partners and was more efficient.
- **Human resources**. Experiences are mixed. UNFPA human resources for sexual and reproductive health and reproductive rights in emergencies coordination and leadership are considered greatly committed and dedicated. At the same time, in view of shortcomings of the global architecture and the Fund's leadership role, interviewees emphasized the need for more investments in staff to allow them to consistently and convincingly promote and lead sexual and reproductive health humanitarian coordination, including at the sub-national level and with a more long-term perspective in protracted crisis situations.

121 Independent Country Programme Evaluation: Liberia 2013-2017.
122 UNFPA Country Programme Evaluation: Myanmar, CP3: 2012-2017.
123 UNFPA Country Programme Evaluation: Sudan, Final Evaluation Report, 6th Cycle Programme 2013-2016.
124 Independent Country Programme Evaluation: Bangladesh 2012-2016.
125 Survey respondents were not required to differentiate between SRH and RR and GBV. Thus, responses were interpreted as applying to SRH and RR and GBV.

4.5.3 UNFPA leadership in gender-based violence humanitarian coordination

SUMMARY:

UNFPA has many years of experience co-leading the gender-based violence area of responsibility of the IASC protection cluster, which interviewed staff considered an advantage, but not a guarantee for the existence of a functioning gender-based violence sub-cluster nor for the undisputed leadership of UNFPA at country level. In 2016, 83 per cent of UNFPA programme countries affected by a humanitarian crisis had a functional inter-agency gender-based violence coordination body as a result of UNFPA coordination and leadership. At the beginning of 2017, UNFPA assumed sole leadership and thus greater responsibility. Low stakeholder awareness and engagement and inadequate coordination expertise and financial resources, which affect the Fund's ability to lead, pose important barriers.

Since its establishment in 2008 until 2017, UNFPA and UNICEF co-led the gender-based violence area of responsibility of the global protection cluster. This cluster oversees the humanitarian community's response to gender-based violence and should result in effective action to mitigate and prevent gender-based violence and promote survivors' access to multi-sectoral services. The UNFPA Strategic Plan 2014-2017 committed the Fund to increasing the percentage of countries affected by a humanitarian crisis that had a functioning inter-agency gender-based violence coordination body as a result of UNFPA guidance and leadership (indicator 10.2). In 2016, 83 per cent of UNFPA programme countries[126] affected by a humanitarian crisis had a functional inter-agency gender-based violence coordination body due to UNFPA coordination and leadership, compared to 54 per cent in 2014 and 38 per cent in 2012.[127]

In 2016, the UNFPA humanitarian consultation recommended, as a matter of priority, that UNFPA take on more leadership of the gender-based violence area of responsibility.[128] At the beginning of 2017, UNFPA assumed sole leadership of the gender-based violence area of responsibility within the global protection cluster.[129] The UNFPA Strategic Plan 2018-2021 reconfirms UNFPA commitment to playing a prominent inter-agency role.[130] Indicator 11.5 measures the proportion of countries affected by a humanitarian crisis that have a functioning inter-agency gender-based violence coordination body as a result of UNFPA guidance and leadership.

The global formalization of the leading role of UNFPA in GBViE, compared to sexual and reproductive health and reproductive rights, is considered an advantage. However, neither the existence of a functioning gender-based violence sub-cluster, nor UNFPA leadership can be taken for granted at country level. Stakeholder awareness of the leading role of UNFPA is not always sufficient and acceptance can be low. In instances, UNFPA human and financial resources are inadequate to demonstrate leadership and earn the necessary respect. To deliver on its mandate, physical presence and coordination at sub-national level is invaluable. Donors are gradually giving more priority to the sub-national level. Locally, UNFPA is more exposed to target populations and decision-takers, than elsewhere. This makes it easier to understand contexts, actors and politics, to ensure mainstreaming of gender and gender-based violence in other sectors, and to be among first responders to acute crises. For example, in Chad, UNFPA facilitation and leadership of the sub-national gender-based violence sub-cluster in the crisis-affected Lake Chad region was recognized by humanitarian actors.[131] In Somalia, UNFPA led the coordination of gender-based violence interventions as the chair of the national gender-based violence sub-cluster within the Somalia protection cluster. UNFPA also strengthened field-based gender-based violence sub-clusters in Puntland, South Central Somalia and Somaliland, thus greatly contributing to enhanced services for survivors.[132] In Sudan, UNFPA formally led the gender-based violence sub-sector group under the protection cluster in Darfur. Its support for coordination in humanitarian settings was commended and attributed to its technical strength and comparative advantage in gender-based violence.[133] Interviews and survey responses indicated

126 2017 progress report, paragraph 52.
127 2015 progress report, table 1 and paragraph 54.
128 2017 progress report, annex 4; UNFPA Humanitarian Action 2017 Overview.
129 2017 progress report, annex 4; UNFPA Humanitarian Action 2017 Overview. Coordination is also a minimum standard as per the UNFPA GBViE standards.
130 UNFPA SP 2018-2021, paragraph 32.
131 Evaluation indépendante du 6ème programme de pays Tchad 2012-2016, février 2016.
132 Independent Country Programme Evaluation: Somalia 2011-2015.
133 UNFPA Country Programme Evaluation: Sudan, Final Evaluation Report, 6th Cycle Programme 2013-2016.

that, in Bangladesh, UNFPA advocacy facilitated the establishment of the gender-based violence cluster co-led by the Ministry of Women and Children Affairs and UNFPA. UNFPA leads the sub-national gender-based violence cluster of the Rohingya refugee crisis response. In Ethiopia, UNFPA leads the gender-based violence sub-cluster at national level as well as—since recently—in three (of nine) regions where it is physically present. At the national level, there is close collaboration with the UNICEF-led child protection sub-cluster. In Mozambique, UNFPA co-leads the protection cluster with UNHCR, which also addresses gender-based violence.

External views

The great majority of external stakeholders consulted as part of this meta-analysis were of the opinion that UNFPA has sufficiently prioritized guidance and leadership for humanitarian coordination in gender-based violence. Responses to how UNFPA could further strengthen its guidance and leadership in GBViE echo those for sexual and reproductive health and reproductive rights with some further specifications:

- Extend humanitarian coordination to local levels
- Build capacities of responsible government entities
- Facilitate communication between high-level and grassroots stakeholders
- Ensure immediate and medium-term availability of qualified and skilled coordination experts for country offices
- Manage gender-based violence sub-clusters within broader protection contexts
- Identify and leverage strengths of each sub-cluster member

Facilitating/constraining factors

Overall, information gathered highlights several factors that have facilitated and/or constrained the guiding and leading role of UNPFA in gender-based violence humanitarian coordination. These are:

- **Global cluster architecture.** Contrary to sexual and reproductive health and reproductive rights, GBViE coordination is a formal area of responsibility delegated to UNFPA. This is clearly considered an advantage, although it does not mean that gender-based violence sub-clusters are universally regularized/activated. Governments and/or humanitarian coordinators may be reluctant or refuse to do so.
- **The leadership role of UNFPA.** Despite its formal lead role, tensions around the leading role of UNFPA in gender-based violence humanitarian coordination at country level are not uncommon. In some instances, donors and governments are confused regarding the division of labour with UN Women, who also have a remit for gender-based violence coordination.
- **Stakeholder engagement.** Successful GBViE coordination depends on the extent to which other partners, including United Nations agencies, engage. Gender-based violence often runs a poor second in terms of humanitarian priority setting. However, besides tensions regarding the lead role, interviewees are largely positive. In one country, the country office appreciates that including gender-based violence in the protection cluster reaches more partners and helps reduce the number of meetings.
- **Human resources.** Information gathered suggests broad satisfaction with available GBViE personnel. This said, more personnel with GBViE would be better. A shortage of locally available skills in gender-based violence and rapid staff turnover[134] (for example, surge personnel) can be a problem. Surge personnel need to have the necessary expertise and competences to coordinate and lead seasoned gender-based violence specialists from other agencies.
- **Sub-national coordination.** Physical presence and coordination at the sub-national level has been invaluable for effective leadership and coordination and relevant support. The security situation, as well as funding and human resource limitations, are constraining factors.

4.6 UNFPA country programme design in highly vulnerable contexts

To what extent are UNFPA country offices in a position to reflect on fragile/humanitarian contexts and formulate support for emergency preparedness and response in country programme documents based on data, evidence and lessons learned?

134 UNFPA Country Programme Evaluation: Sudan, Final Evaluation Report, 6th Cycle Programme 2013-2016.

SUMMARY:
Information gathered suggested that UNFPA country offices working in highly vulnerable contexts have strived to construct their country programmes on data, evidence and lessons learned. It is at least likely that country offices have gathered and analysed new data for the specific purpose of designing country programmes. Vulnerable population groups have been consulted as part of country programme design, either directly or through civil society representatives. UNFPA staff interviews and country office surveys suggested that it is important for UNFPA to be engaged in scenario planning and subsequent programme adaptations throughout the programme cycle.

The 2016 UNFPA humanitarian consultation recommended that UNFPA should increase investments in humanitarian data, risk/resilience/vulnerability analysis and information management. According to the UNFPA Strategic Plan 2018-2021, "UNFPA will strengthen risk-informed programming in the formulation and design of resilience-focused country programmes, including strengthening internal capacity for risk-informed resilience programming, monitored through existing quality assurance mechanisms".

Of the 27 country programme documents developed in 2015, 23 incorporated risk analyses.[135] Eleven country offices responding to the survey confirmed that they had used existing humanitarian data and risk/resilience/vulnerability analyses/maps to formulate their most recent country programme documents. Six country offices had commissioned/participated in new data-gathering and analysis on vulnerability for the explicit purpose of designing their programmes. In addition to country data, the following typically available types of datasets/analyses were considered useful:

- World Risk Index
- Demographic and Health Survey (DHS)
- Post-Disaster Needs Assessment (PDNA)
- Multi-Cluster/Sector Initial Rapid Assessment (MIRA)
- IOM Displacement Tracking Matrix (DTM)[136]
- OCHA humanitarian needs comparison tool
- Gender-Based Violence Information Management System (GBVIMS)
- Census and census-based population projections
- Health Management and Information System (HMIS)

Eleven country offices responding to the survey had specifically considered lessons learned from past humanitarian programming when formulating their most recent country programmes. In addition, nine country offices had consulted vulnerable/affected population groups. Reasons provided for not conducting such consultations were the national execution programme implementation modality, scarce country office human resources, limited access to beneficiaries and no need because of simultaneous joint consultations organized by the Humanitarian Country Team in connection with the common country assessment. Country offices conducted focus group discussions with vulnerable population groups and service providers serving those groups as well as community-level meetings; they consulted and shared drafts with non-governmental organization representatives.

Although not part of the interview guide, interviews also confirmed the view that humanitarian programming needs to be integrated in UNFPA country programme documents and country programme action plans (CPAPs) based on evidence, especially in protracted crisis situations. The INFORM Index and, generally-speaking, inter-agency risk assessments were mentioned as good sources of information. It was suggested that country offices in stable situations may be less willing to invest in risk assessments.

While it is important to build country programme documents and/or country programme action plans on risk assessments and align them with national contingency/response plans, interviews and the country office survey also suggested that it is important for UNFPA to be continually engaged in scenario planning and subsequent programme adaptations. Eight of 11 country offices confirmed that they had adjusted their country programme action plans' results and resources framework outputs/indicators and/or (annual) work plans, including reprogramming of funds, at the onset of a humanitarian emergency, and this included deleting certain development interventions. One example is Ukraine, where the country programme was updated with new outputs reflecting the emerging humanitarian needs in the Eastern oblasts.[137] Three country offices mentioned having paid more attention to risk with the help of a programme criticality assessment.

135 2016 progress report, annex 5; UNFPA Humanitarian Action 2016 Overview.
136 http://www.globaldtm.info/.
137 Evaluation of the 2nd UNFPA Country Programme for Ukraine 2012-2017.

4.7 Operations

To what extent are UNFPA country offices in a position to deliver efficient and effective support for emergency preparedness and response from an operational point of view?

4.7.4 Funding for humanitarian programming

SUMMARY:
In 2016, the UNFPA humanitarian consultation highly recommended that UNFPA revamp its funding mechanisms to effectively and efficiently finance humanitarian operations. The evaluation of the UNFPA Strategic Plan 2014-2017 architecture found that regular resource allocation criteria were inadequate to ensure the most effective allocation of resources to vulnerable contexts. Staff interviews and survey responses confirmed that funding for emergency preparedness and response programming remained insufficient, including for core staffing. Nevertheless, the regular resource-allocation system was not revised to better take fragility and risk of humanitarian crises occurring into account. Although reliable and a timely source of funding, the UNFPA emergency fund has, measured against needs, faced resource constraints; funding from external sources, such as the United Nations Central Emergency Response Fund has not met requirements. The humanitarian response reserve was not activated due to financial austerity measures. In view of the increasing emphasis on the humanitarian-development nexus, the flexible use of humanitarian and development funds has become even more relevant. Looking ahead, more effective resource mobilization will be key.

In 2016, the UNFPA humanitarian consultation highly recommended that UNFPA revamp its funding mechanisms to effectively and efficiently finance humanitarian operations. Staff interviews and survey responses confirmed that funding for emergency preparedness and response programming remained inadequate.

Regular resources for humanitarian programming

Thirty six of the 49 countries facing a high or very high risk of a humanitarian emergency according to INDEX 2018, and 21 of 25 UNFPA priority humanitarian countries, appear in the red quadrant.[138] The evaluation of UNFPA Strategic Plan 2014-2017 architecture found that "there has been an increase in the proportion of regular resources allocated to countries with the greatest need and the lowest ability to finance, but existing allocation criteria may not be enough to ensure the most effective allocation of resources". Resources for the red quadrant increased from 52 per cent of total regular resources to country programmes in 2014 to 57 per cent in 2016. However, austerity measures were introduced and regular resource allocations revised downwards. In absolute terms, regular resources declined. The lack of funding floors for budget allocations meant that budgets were not protected. In view of this, several countries argued that fragility and risk of humanitarian crises occurring should be a stronger feature of the resource-allocation system, including resources for covering high staff and operational costs, which donors are not inclined to fund, and which the UNFPA emergency fund can only cover in the short term.[139] However, UNFPA Strategic Plan 2018-2021 maintains the same weight for the humanitarian/risk factor. Staff interviews conducted as part of this meta-analysis suggested that a greater emphasis on preparedness programming also necessitated more regular resources. All but one country office responding to the survey felt that the resource-allocation system 2018-2021 is unlikely to satisfy their regular resource needs for UNFPA humanitarian programming.

The case from UNFPA Strategic Plan 2014-2017 for more a flexible use of available funds has become all the more relevant in view of the increasing emphasis on the humanitarian-development nexus: "… countries facing prolonged humanitarian crises may be unable to spend 'development' resources because of the operating environment but have nonetheless been slow to shift these resources to humanitarian efforts. Becoming less rigid in the distinction between the two will enable the organization to operate more effectively, particularly in prolonged humanitarian situations".[140] For example, in the Ebola-affected countries, country offices were permitted to switch programme funds to emergency funds[141] and to reallocate funding to the affected areas.[142] On the contrary, in Sudan, interventions in humanitarian settings

138 UNFPA SP 2018-2021 annex 4, table 3.
139 Evaluation of SP 2014-2017 architecture. The emergency fund can support staff costs, but only in the short term. Almost one third of the 2016 emergency fund allocation was spent on human resources, in the main surge capacity and short-term staff. However, funding through the emergency fund can only extend up to the end of the calendar year in which it is drawn.
140 SP 2014-2017 annex 3, paragraph 32.
141 2015 progress report, paragraph 42.
142 Evaluation indépendante du 7è programme de pays UNFPA/Guinée, Rapport Final, Août 2016.

were found to be dependent on the ability of UNFPA to raise donor funding, since no core resources were committed and this affected their sustainability.[143] Similarly, in Somalia, Somaliland was initially excluded from UNFPA humanitarian assistance for lack of sufficient funding, despite its needs.[144] The country programme document for Nepal for the programme period 2018-2022 makes the case for more flexibility: "in unforeseen circumstances, such as humanitarian emergencies, UNFPA may seek to re-programme funding—thematically and/or geographically—in consultation with the Government, and towards activities aligned with UNFPA's mandate".

Availability of emergency funds

UNFPA country and regional offices confronted with potential or acute crises have accessed funding from the UNFPA emergency fund as well as from external sources. No funds have been allocated to the UNFPA humanitarian response reserve due to financial austerity measures.

UNFPA emergency fund and humanitarian response reserve

The evaluation of the UNFPA Strategic Plan 2014-2017 architecture found that "UNFPA has successfully mobilised resources to support humanitarian crises, but key mechanisms such as the emergency fund and humanitarian response reserve have faced resource constraints".[145] The following statistics support this observation:

- From 2008 to November 2016, 85 UNFPA country offices received emergency fund disbursements with a total value of $29.87 million.[146]
- Due to austerity measures, allocations to the emergency fund were significantly less than expected in 2015 and 2016. They were $5 million and $2 million respectively (instead of an intended $10 million each).[147]
- Allocations from the emergency fund were made to 24 countries in 2014 and 22 countries in 2015.[148]
- The top recipient countries of emergency fund allocations in 2015 included Level-3 emergencies (Nepal, Yemen, South Sudan, and Turkey/Syria) and UNFPA response to the Vanuatu earthquake.[149]
- Thirty per cent of all emergency fund allocations in 2015 were requested for complex emergencies, 30 per cent for conflicts, 29 per cent for natural disasters, and 11 per cent for preparedness.[150]
- In 2016, 30 country offices received emergency funds, with $4.87 million disbursed.[151]
- In 2016, the emergency fund was able to meet 78 per cent of total requests, an increase of 16 per cent compared to 2015 (62 per cent), and of 34 per cent compared to 2014 (which was 44 per cent).[152]
- In 2016, the average emergency fund allocation amount per country was $162,401, a decrease from the average amount awarded in the two prior years, which was $197,099 in 2015 and $206,335 in 2014.[153]
- In 2016, 39 per cent of UNFPA emergency fund resources were allocated in response to natural disasters, including hurricanes in Cuba and Haiti, earthquakes in Ecuador and Nepal, cyclones in Bangladesh and Fiji, floods in Kenya and Paraguay, drought in Swaziland, drought and floods in Somalia and the Zika epidemic in Brazil.[154]
- In 2016, responses to complex emergencies (28 per cent of all emergency fund allocations) included refugees from the Central African Republic in the Republic of the Congo, Yemeni refugees in Djibouti, refugees and internal displaced persons in Iraq, and reproductive health programming for the Syrian crisis in Jordan.[155]
- In 2016, UNFPA support from the emergency fund for emergency preparedness amounted to 28 per cent—allocated to Cameroon, Mali, Nigeria, South Sudan, Turkey and Yemen.[156]
- In 2016, the Arab States region received the most emergency fund disbursements, with eight in total, followed by the West and Central Africa and East and Southern Africa regions, which received seven disbursements each. Latin America and the Caribbean received six disbursements, Asia and the

143 UNFPA Country Programme Evaluation: Sudan, Final Evaluation Report, 6th Cycle Programme 2013-2016.
144 Independent Country Programme Evaluation: Somalia 2011-2015.
145 Evaluation finding 10.
146 DP/FPA/2017/CRP.3: UNFPA humanitarian response funding, 5 January 2017.
147 Evaluation of SP 2014-2017 architecture.
148 As well as two sub-regional offices and one regional office. Source: 2016 progress report, annex 5.
149 2016 progress report, annex 5.
150 2016 progress report, annex 5.
151 DP/FPA/2017/CRP.3: UNFPA humanitarian response funding, 5 January 2017; UNFPA Humanitarian Action 2017 Overview.
152 DP/FPA/2017/CRP.3: UNFPA humanitarian response funding, 5 January 2017.
153 DP/FPA/2017/CRP.3: UNFPA humanitarian response funding, 5 January 2017.
154 DP/FPA/2017/CRP.3: UNFPA humanitarian response funding, 5 January 2017.
155 DP/FPA/2017/CRP.3: UNFPA humanitarian response funding, 5 January 2017.
156 DP/FPA/2017/CRP.3: UNFPA humanitarian response funding, 5 January 2017.

Pacific received five, and Eastern Europe and Central Asia received three.[157]

- In 2016, emergency fund allocations in the amount of $1.76 million (57.7 per cent) was spent on sexual and reproductive health and reproductive rights and $1.18 million (38.8 per cent) on gender-based violence; 3.1 per cent was invested in data on population and development and less than 1 per cent on adolescent sexual and reproductive health and data for monitoring and evaluating policies respectively.[158]
- Emergency funds have been distributed in a timely manner—the time between submitting a proposal and receiving approval was 1.8 days in 2016, compared to 2.8 days in 2014 and one day in 2015.[159]
- Emergency fund utilization rates in any given year were 95-96 per cent.[160]

In 2016, 47 per cent of UNFPA country offices receiving emergency fund allocations also received United Nations Central Emergency Response Fund (CERF) funding as opposed to 54 per cent in 2014 and 48 per cent in 2015. These figures indicate that the emergency fund is increasingly utilized in contexts that would otherwise not have received CERF or other funding.[161]

At its first regular session in 2017, the UNFPA Executive Board reviewed a conference room paper on the UNFPA emergency fund and humanitarian response reserve between 2008 and 2016.[162] The paper concluded that, although limited, the UNFPA emergency fund has become an increasingly reliable and timely source of initial humanitarian funding, strengthening UNFPA capacity and enabling it to provide timely, life-saving support for response and preparedness activities in a multitude of contexts around the world. With additional financial support, UNFPA would be better positioned to deliver on its core objectives related to humanitarian response. UNFPA capacity would be further strengthened by the humanitarian response reserve. Staff survey participants urged UNFPA to expand the allocation and the scope of the emergency fund, including to support personnel deployment for at least one year, and to streamline the emergency fund application process, as well as to activate the humanitarian response reserve as soon as possible. One interviewee suggested introducing a UNFPA pre-financing mechanism for rapid response.

Humanitarian funding from external sources

UNFPA has also received emergency funding from external sources—including the Central Emergency Response Fund (CERF) and other United Nations joint funding mechanisms, as well as individual donors. Despite increases over the years, external contributions for UNFPA humanitarian programming have not satisfied requirements.

Humanitarian funding for UNFPA increased substantially in 2014, from $41 million in 2013 to $101 million.[163] UNFPA attracted even more funding in 2015, specifically $116.2 million.[164] In 2016 it grew once more to $155 million[165] and in 2017 to $216 million.[166] However, this upward trend has not kept up with the significant increase in requests, specifically, $312 million in 2016[167] and $425 million in 2017.[168] The estimated required humanitarian funding for 2018 is $463 million.[169]

In 2016 and 2017, the top humanitarian donors to UNFPA were Canada, the United States, OCHA other United Nations humanitarian pooled funds (including CERF), the European Commission, Sweden, Japan, Denmark, Australia, and the Netherlands.[170]

The extent to which country needs were satisfied varied considerably. Of the $203 million requested from external sources in 2015, an overall 41 per cent was covered, ranging from zero per cent for Uganda, Chad, Burkina Faso, Mali, Guatemala, Djibouti, Haiti and Senegal to 131 per cent for Ukraine ($1.4 million).[171] Of the $312 million requested from external sources in 2016, an overall 51 per cent was covered, ranging from zero per cent for Burkina Faso to 187 per cent for Iraq ($22.2 million).[172] Of the $425 million requested in 2017, an overall 51 per cent was covered, ranging from zero per

157 DP/FPA/2017/CRP.3: UNFPA humanitarian response funding, 5 January 2017.
158 DP/FPA/2017/CRP.3: UNFPA humanitarian response funding, 5 January 2017.
159 Evaluation of SP 2014-2017 architecture; DP/FPA/2017/CRP.3: UNFPA humanitarian response funding, 5 January 2017.
160 Evaluation of SP 2014-2017 architecture.
161 DP/FPA/2017/CRP.3: UNFPA humanitarian response funding, 5 January 2017.
162 DP/FPA/2017/CRP.3: UNFPA humanitarian response funding, 5 January 2017.
163 2015 progress report, paragraph 77.
164 2016 progress report, annex 5.
165 2017 progress report, annex 4.
166 UNFPA Humanitarian Action 2018 Overview.
167 Evaluation of SP 2014-2017 architecture, pp. 25 and 26.
168 UNFPA Humanitarian Action 2018 Overview.
169 UNFPA Humanitarian Action 2018 Overview.
170 UNFPA Humanitarian Action 2017 Overview; UNFPA Humanitarian Action 2018 Overview.
171 UNFPA Humanitarian Action 2016 Overview.
172 UNFPA Humanitarian Action 2017 Overview.

cent for Ghana, Guinea-Bissau and Sri Lanka to 106 per cent for Myanmar ($3.2 million).

The CERF is an important funding source for UNFPA humanitarian work**.** In 2016, the CERF supported UNFPA interventions in 33 countries with a total of $23.1 million, which represented a 44 per cent increase from the CERF allocation of $16.1 million in 2015.[173] For example, most of the additional resources for DPRK during 2011-2014 were CERF funding ($49 million) in response to the floods of 2012 and 2013, which, albeit less than hoped for, represented 24 per cent of all humanitarian funding received by UNFPA for DPRK in the past 10 years.[174] The Sudan country programme also benefited from CERF—approximately, $2.5 million for 2013 and 2014.[175]

At the World Humanitarian Summit, and within the context of the "Grand Bargain",[176] UNFPA committed itself to providing at least 25 per cent of humanitarian funding to local and national responders. In 2016, more than 35 per cent of CERF contributions to UNFPA were disbursed to (international) non-governmental organisations, Red Cross and Red Crescent Societies and government partners, a steady increase from 2014 and 2015.[177] The latest survey conducted by Local to Global Protection in November 2017 revealed UNFPA as the top agency providing funding to local and national responders. Thanks to a series of actions to improve timeliness of disbursements of CERF funds, information as of April 2017 reveals that, on average, it took 26 days to advance funds to implementing partners. This is more than 30 days faster, or more than 55 per cent better, than when consistent tracking and monitoring started.[178]

Effective resource mobilization is an issue**.** Asked for recommendations on how to ensure that UNFPA humanitarian operations are adequately financed, survey participants' main concerns revolved around effective resource mobilization. A suggestion was made that UNFPA develop a resource-mobilization strategy for humanitarian situations. Requests were made for more support from UNFPA headquarters and regional offices—for example, in identifying predictable/stable sources of funding, approaching donor countries at the onset of emergencies, and strengthening country office staff capacities for successful resource mobilization. Moreover, the wish was voiced for more flexibility to approach private donors and to undertake joint mobilization.

4.7.5 Human-resource capacities

SUMMARY:

The 2016 humanitarian consultation recommended that UNFPA align its human resource capacity to deliver in humanitarian contexts. The evaluation of the UNFPA Strategic Plan 2014-2017 architecture found a lack of evidence that the necessary processes were in place to ensure appropriate capacity to meet strategic plan requirements. The UNFPA Strategic Plan 2018-2021 acknowledges that country offices in the red quadrant, to which most humanitarian programmes belong, will require a larger number of staff, including staff with experience in managing complex programmes. Currently, it appears that UNFPA runs a real risk of overwhelming country office staff. Work-life balance is an issue. Interviews called for more dedicated humanitarian aid staff capacities in order to credibly engage with other humanitarian actors. Sub-national level presence has been invaluable for UNFPA engagement. Areas of expertise required for working in highly vulnerable contexts are preparedness planning and disaster risk reduction; procurement and logistics; monitoring and evaluation in emergencies; and humanitarian coordination. There has been a process to develop surge capacity to respond to humanitarian situations, and this has been very useful, but clearly not sufficient to fill long-term capacity gaps. Country offices have not been able to rely on surge personnel being deployed in a timely manner and with the necessary competences.

The UNFPA Strategic Plan 2014-2017 identified the need to adjust human-resource capacities to meet the differing needs of country offices in different quadrants—in terms of staff skills and in numbers of staff. The UNFPA 2016 humanitarian consultation recommended that UNFPA align its human-resource capacity to deliver in humanitarian contexts. The evaluation of the UNFPA Strategic Plan 2014-2017 architecture found that "alignment of human-resource capacity at country level to the needs of the strategic plan has been slow and there is no evidence

173 UNFPA Update on CERF grant support to UNFPA emergency interventions for women and girls, May 2017.
174 UNFPA Country Programme Evaluation: the Democratic People's Republic of Korea Fifth Programme Cycle, 2011-2015/6.
175 UNFPA Country Programme Evaluation: Sudan, Final Evaluation Report, 6th Cycle Programme 2013-2016.
176 The Grand Bargain is an agreement between more than 30 of the biggest donors and aid providers, which aims to get more means into the hands of people in need. The Grand Bargain was first proposed by the former UN Secretary General's High-Level Panel on Humanitarian Financing in its report "Too important to fail: addressing the humanitarian financing gap" as one of the solutions to address the humanitarian financing gap. For more information: https://www.agendaforhumanity.org/initiatives/3861.
177 UNFPA Update on CERF grant support to UNFPA emergency interventions for women and girls, May 2017.
178 UNFPA Update on CERF grant support to UNFPA emergency interventions for women and girls, May 2017.

that processes are fully in place to ensure appropriate capacity to meet the requirements of the strategic plan".[179] In particular, the evaluation revealed that limited technical capacity at country level impacted on the level of preparedness planning. Furthermore, the UNFPA Strategic Plan 2018-2021 acknowledges that country offices in the red quadrant, to which most humanitarian programmes belong, will require a larger number of staff, including staff with experience in managing complex programmes.[180]

Currently, it appears that UNFPA runs a real risk of overwhelming country office staff in highly vulnerable contexts. Interviews clearly confirmed human-resource capacity gaps and the need to continue realigning and increasing (including through training) staff capacities for humanitarian programming in order to reliably fulfil the UNFPA mandate and achieve expected results at country and regional levels. Interviews emphasized the importance of having adequate human resources to promote national preparedness. Upstream policy dialogue and advocacy competences were considered key for influencing national prioritization of the UNFPA mandate in emergencies. Interviewees also called for more dedicated humanitarian aid staff capacities in order to credibly engage with other humanitarian actors. A great challenge is to consistently ensure knowledgeable participation and leadership in both sexual and reproductive health and gender-based violence clusters. Humanitarian staff need to be convincing in order to be effective. Survey participants were asked about essential skills necessary for delivering in highly vulnerable contexts. The following areas of expertise were at the top of their list:

- Procurement and logistics
- Monitoring and evaluation in emergencies
- Humanitarian coordination
- Preparedness planning and disaster risk reduction

GBViE, sexual and reproductive health and reproductive rights specialists and coordinators at sub-national level have been invaluable for UNFPA engagement. For instance, UNFPA support for gender-based violence data collection, storage and analysis in the eastern region of Chad was facilitated by the presence of its sub-office in Abéché.[181] Staff interviews indicated that, in DRC, all decentralized office staff are dedicated to the humanitarian response, including monitoring and humanitarian coordination. Sub-national coordinators in the major United Nations humanitarian hubs in Yemen are helping to strengthen gender-based violence activities. Sub-national humanitarian reproductive health staff are key to the response in Ethiopia.

Surge capacity

The Organizational Effectiveness and Efficiency, output 2, indicator 2.3 of the UNFPA Strategic Plan 2018-2021, anticipates an increase in the proportion of humanitarian emergencies in which surge deployment is achieved within lead response time. In 2015, the roster of trained UNFPA staff was 96 members, of which UNFPA deployed 13 individuals.[182] By November 2016, these numbers had grown to 206 members and the deployment of 56 surge personnel.[183] At the time of writing, the roster contained 300 persons. UNFPA is specifically committed to scaling up UNFPA GBViE response. Currently, 60 per cent of UNFPA surge personnel have profiles dealing with gender-based violence. In addition, UNFPA was able to benefit from external stand-by rosters.[184] In 2016, standby partners deployed staff to 12 UNFPA country offices.[185] Standby partners include Danish Refugee Council, Norwegian Refugee Council, International Civilian Response Corps and RedR Australia. Partnerships are being explored with the Swedish Civil Contingencies Agency and the Swiss Agency for Development and Cooperation.[186]

Information gathered revealed that the process to develop surge capacity for responding to humanitarian situations has been very useful, but clearly not sufficient to fill long-term capacity gaps—for example, in protracted crisis situations.[187] Of those 13 country offices participating in the survey, 10 had received surge personnel for responding to humanitarian situations, mainly humanitarian coordinators, gender-based violence and sexual and reproductive health and reproductive rights specialists and health coordinators. Experiences were overall positive—examples of comments include "extremely important", "mostly very knowledgeable", "emboldened the country office response", "invaluable", "filling important staffing gaps", "good mechanism". Interviews and surveys also suggested that it was not sufficient, in ensuring continuity

179 Evaluation finding 8, p. 22.
180 UNFPA SP 2018-2021 paragraph 54.
181 Evaluation indépendante du 6ème programme de pays Tchad 2012-2016, février 2016.
182 2016 progress report, paragraph 56.
183 2017 progress report, annex 4; UNFPA Humanitarian Action 2017 Overview.
184 2016 progress report, annex 5; 2017 Progress Report, annex 4.
185 2017 progress report, annex 4.
186 UNFPA Humanitarian Action 2017 Overview.
187 *Inter alia,* Evaluation of SP 2014-2017 architecture, p. 24.

(in protracted crises) and sustainability of response, for surge personnel to only remain on location for three to six months and then relocate to another emergency or return to their regular positions. Neither was it ideal, when deployed surge personnel remained in charge of their regular work and were obliged to handle two jobs at the same time. Internal surge personnel generally have the advantage of being more familiar with UNFPA procedures (as opposed to external personnel). Especially in the case of external surge personnel, care should be taken to bring them properly on board, by providing extra coaching—for example, on procurement rules in emergencies in order to be audit compliant—or by introducing twinning arrangements. One suggestion was made to consider establishing roving/stand-by humanitarian teams with full-time contracts.

Human-resource challenges

Perceived challenges are:

- Country office staff are overburdened and stressed by the mental and time requirements of implementing country programmes and participating in coordination mechanisms in highly vulnerable contexts. Work-life balance can be a serious issue causing burn-outs and high turnover.
- Inconsistent staffing is a challenge, in terms of available competences—humanitarian programming and upstream engagement.
- ·Reliance on short-term local contractors, instead of being able to recruit fixed-term staff, threatens stability and sustainability.
- While highly valued, surge personnel are not deployed sufficiently long-term for contracted emergencies. In acute emergencies, it has taken too long for their deployment. Neither are they always sufficiently familiar with UNFPA or the subject matter.
- Time is needed to fulfil a plethora of corporate headquarter requirements. This takes the time away from saving lives.
- 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.

4.7.6 Regional office and headquarter support for country offices

SUMMARY:
UNFPA headquarter and regional offices have provided useful support to country offices, although the very few regional office humanitarian focal points/coordinators were not always able to respond to all requests. Concrete benefits were noted in the areas of human resources deployment; resource mobilization; humanitarian commodities procurement and logistics; advocacy and communications; humanitarian mainstreaming; MISP capacity building; GBViE leadership and coordination; and creation of a sub-national humanitarian hub.

UNFPA global support is coordinated by the Humanitarian Steering Committee, chaired by the Executive Director, and supported by HFCB, as well as an inter-divisional working group and the UNFPA regional offices.[188] Regional offices are guided by regional programmes. Both the latest regional programme for Eastern Europe and Central Asia (EECARO) and West and Central Africa regional office (WCARO), for example, specifically include support for UNFPA country offices' humanitarian programming. However, with only one humanitarian focal point/coordinator per regional office, capacity gaps have also existed at the regional level. The evaluation of the UNFPA Strategic Plan 2014-2017 architecture found that regional office humanitarian focal points/coordinators, especially in regions with high demand, were not always able to respond to all requests for support. To some extent, UNFPA headquarters has attempted to fill the gap through direct support for country offices.[189]

UNFPA annual reports provide some examples of regional office support: In 2014, EECARO piloted a MISP-readiness assessment methodology for supporting integration of sexual and reproductive health and reproductive rights into national emergency preparedness plans. This methodology was considered a good example for replication in other countries.[190] In 2015, the UNFPA Asia and Pacific regional office (APRO) pre-positioned $478,000 worth of sexual and reproductive health and gender-based violence commodities in Myanmar, Nepal, the Philippines, Papua New Guinea and Fiji as part of the regional pre-positioning

188 UNFPA Humanitarian Action 2017 Overview.
189 *Inter alia,* Evaluation of SP Architecture.
190 2015 progress report, paragraph 41.

initiative.[191] In 2015, LACRO supported the development of a geo-referenced application for identifying and processing sexual and reproductive health data for disaster preparedness and response in the region.[192]

All but 1 of the 13 country offices responding to the survey had received support from UNFPA headquarters and/or regional offices for emergency preparedness and response. Of those, eight appreciated the support as "very useful"; four as "useful". Thanks to such support, country offices noted benefits in the areas of:

- Human resources deployment (including surge capacities)
- Resource mobilization, including from UNFPA emergency fund
- Humanitarian commodities procurement and logistics
- Advocacy and communications
- Humanitarian mainstreaming
- MISP capacity building
- GBViE leadership and coordination
- Creation of a sub-national humanitarian hub

4.7.7 Procurement and distribution of humanitarian supplies

SUMMARY:
In 2016, over 60 per cent of total procurement was carried out by the UNFPA Procurement Services Branch Functioning procurement processes and distribution systems are key to pre-positioning and—in acute crisis situations—delivering humanitarian supplies. Pre-positioning at regional, national and sub-national levels has been a particularly important aspect of UNFPA emergency preparedness work in highly vulnerable contexts, especially when humanitarian crises can be anticipated. While there are very good examples, procurement has posed difficulties to delivering on the UNFPA mandate and consequently receiving the recognition and respect the organization deserves as a humanitarian actor. Reasons for this include the absence of an organization-wide comprehensive supply chain management strategy for humanitarian settings; reliance on central procurement; stock outs; delays; corporate barriers to pre-positioning; inadequate procurement and logistics management knowledge at country level; and little use of logistics partnerships.

Procurement is undertaken by the UNFPA Procurement Services Branch located in Copenhagen as well as by UNFPA regional and country offices. In 2016, over 60 per cent of the total procurement volume was carried out by the procurement services branch.[193]

UNFPA strategic plans do not dwell on procurement of (humanitarian) supplies. Where they do mention procurement, it is in connection with national capacity building. According to the UNFPA Strategic Plan 2014-2017, "less frequently, UNFPA will be directly involved in service delivery, such as the procurement of commodities, which the organization will continue to do, although this will be paired with capacity development, so that countries can assume direct responsibility for it". According to the UNFPA Strategic Plan 2018-2021, UNFPA will focus on "strengthening capacities to effectively forecast, procure, distribute and track the delivery of sexual and reproductive health commodities, ensuring resilient supply chains". Furthermore, "Service delivery refers to the provision of effective, safe, comprehensive, life-saving and high-quality reproductive health and/or gender-based violence services, supplies or commodities to bridge the essential gaps in countries, predominantly in the red quadrant, and to address critical needs in humanitarian crisis situations. It includes the following: procurement—UNFPA directly procures some reproductive health commodities and also plays a direct role in quality assurance of these products. In both instances, this service delivery is typically coupled with capacity development efforts so that countries ultimately are able to do their own procurement…".[194]

The 2016 humanitarian consultation highly recommended that UNFPA strengthen supply chain management to be more responsive to humanitarian contexts. Some suggested improvements were: (i) more flexible quality assurance for local procurement; (ii) pre-positioning of kits based on a factual analysis of the operating context; (iii) redesigned emergency reproductive health kit packaging that avoids wastage; and (iv) measures to improve tracking and monitoring of the distribution of kits and supplies.

All but 2 of the 13 country offices responding to the survey have pre-positioned humanitarian supplies; all have distributed humanitarian supplies in times of

191 2016 progress report, annex 5.
192 2016 Progress Report, annex 5.
193 http://www.unfpa.org/about-procurement.
194 UNFPA SP 2018-2021 annex 4, paragraph 32(e).

crisis. Functioning procurement processes and distribution systems are key to pre-positioning and—in acute crisis situations—delivering humanitarian supplies. According to interviews, supplying commodities—for example, as part of the MISP—was experienced as being less complex than other interventions, though not without its own challenges. While there are very good examples, procurement has posed difficulties to delivering on the UNFPA humanitarian mandate. Consequently, UNFPA has not received the recognition and respect it deserves as a humanitarian actor.

Pre-positioning at regional, national and sub-national levels has been a particularly important aspect of UNFPA emergency preparedness work in highly vulnerable contexts, especially when humanitarian crises can be anticipated (for example, elections or hurricane season) or in contexts where survivors are difficult to access physically (for example, Nepal).[195] Further examples include, the UNFPA response, including providing reproductive health supplies, to emerging reproductive health needs of flood-affected populations in parts of Sudan was facilitated by the existence of state UNFPA offices.[196] In Panama, UNFPA was able to pre-position locally procured dignity kits in the WFP humanitarian response depot. In Ethiopia and Mozambique, UNFPA also benefited from WFP warehousing and transportation systems. In 2015, APRO pre-positioned $478,000 worth of sexual and reproductive health and gender-based violence commodities in Myanmar, Nepal, the Philippines, Papua New Guinea and Fiji, as part of a regional pre-positioning initiative, enabling an immediate response to earthquake-affected areas in Nepal.[197] On the other hand, in DPRK and Turkey, the UNFPA emergency response to both flooding and the respective influx of Syrian refugees, was delayed by weaknesses in terms of pre-positioning.[198] In DPRK, UNFPA provided reproductive health emergency kits, midwifery kits, hygiene kits and essential drugs in response to floods in 2012 and 2013 in its 11 focus counties, plus an additional 9 affected counties. Because kits were only available about six months after the flooding occurred, UNFPA subsequently decided to pre-position emergency stocks in the central warehouse in Pyongyang.[199]

An evaluation published in November 2017 revealed particular logistical challenges associated with emergency reproductive health kits**.** It concluded that investing in capacity and systems building for sustainable supply chains needed to be a top priority, to ensure that the right people in the right contexts were ordering the right amount of kits for the right period of time. This would not only reduce over-ordering and waste, but would ensure that timely and context-appropriate life-saving medical commodities arrived where they were most needed.[200]

Challenges and lessons learned

Overall, information gathered suggested the following lessons learned and areas for further analysis:

- **Procurement vision and focus**. While procurement appears in the narrative of UNFPA strategic plans and various rules, regulations and guidelines have been issued—for example, regarding reproductive health kits and inventory management—the Fund does not have an organization-wide comprehensive supply chain management strategy for humanitarian settings. This was considered a weakness in terms of focusing the procurement mandate, clarity of purpose and efficiency of UNFPA.
- **Central procurement.** Local and regional procurement is possible under certain circumstances—for example, of pharmaceuticals, medical devices and dignity kits. Even so, numerous interviewees from regional and country offices were concerned that the Fund was still overly reliant on central procurement, to which the interviewees attributed a range of delivery problems.
- **Delivery.** While positive feedback was also received, the general resonance was critical. Several factors at global and country levels were considered to have contributed to delivery problems in the recent past. These included:
  - A limited array of global suppliers for certain items such as pharmaceuticals, medical devises and contraceptives
  - Missing long-term agreements at country level
  - Stock outs—required items not readily available at central level, especially for large-scale humanitarian responses

195 *Inter alia,* Lessons learned, p22; UNFPA Country Programme Evaluation: the Democratic People's Republic of Korea Fifth Programme Cycle, 2011-2015/6; e.g., decentralise pre-positioning to the regional level in order to save valuable time in preparation for the hurricane season in Latin America and the Caribbean.
196 Country Programme Evaluation UNFPA Sudan, Final Evaluation Report, 6th Cycle Programme 2013-2016.
197 2016 progress report, annex 5.
198 Lessons learned, p. 22.
199 UNFPA Country Programme Evaluation: the Democratic People's Republic of Korea Fifth Programme Cycle, 2011-2015/6.
200 November 2017 Evaluation of ERH Kits. Recommendations made by the evaluation team are not systematically included here.

- Finding a balance between standardizing/pre-defining humanitarian commodities—for example, contents of dignity kits for immediate relief—versus adapting to programme government requirements/beneficiary needs
- Difficulties finding timely transportation for large or sensitive (for example, cold chain) items
- Very high freight costs in some circumstances
- Inefficient duplicate orders placed by country offices because of sporadic donor funding
- Inadequate procurement and logistics management knowledge at country level[201]
- Late involvement of operations in humanitarian programming
- Limited capacities of local vendors, especially in crisis situations
- Insufficient pre-positioning of emergency stocks

- **Pre-positioning.** While country offices have pre-positioned commodities, more could be done. Problems mentioned are the low financial risk threshold for loss and disposal of expired items as per UNFPA policy for inventory management; the need to request authorization to pre-position on an annual basis; and unavailability of adequate storage facilities. HFCB is currently elaborating guidance for UNFPA humanitarian pre-positioning.
- **Partnerships.** While some good examples exist of collaboration with WFP, there seems to be scope for strengthening collaboration within the WFP-led logistics cluster. Room for the health cluster to partner more closely with UNHCR as the lead agency for camp and tent management was also mentioned.
- **Waste.** Over-ordering in order to increase visibility and disbursement rates, to adhere to donor deadlines and to procure kits for individual items has resulted in (medical) waste.
- **Monitoring**. The importance of ensuring and tracking proper and efficient distribution and utilization of supplies was emphasized.

4.7.8 Fast-track procedures

SUMMARY:
The revised UNFPA fast-track procedures have provided operational authority and flexibility in fragile contexts, especially in terms of staff recruitment and commodities procurement. However, there appears to be room for UNFPA to further increase operational flexibility in protracted emergencies, fragile contexts and especially in high-security settings. Nimbler procedures—for example, automatic activation for all emergency levels—would allow UNFPA to reach its full potential in effectively and efficiently addressing vulnerabilities.

In 2015, UNFPA overhauled its fast-track procedures (FTPs). The 2016 UNFPA humanitarian consultation recommended that UNFPA further increase operational flexibility for UNFPA country offices in protracted emergencies, fragile contexts and especially in high-security settings.[202]

Working in highly vulnerable contexts requires agility and flexibility to adapt and differentiate. In 2016, 31 country offices and 3 regional offices had activated the fast-track procedures.[203]All but 1 of the 13 country offices responding to the survey had activated the fast-track procedures on one or more occasion since 2014. All 12 confirmed that the fast-track procedures provided operational authority and flexibility in fragile contexts. In particular, they appreciated fast-track activation in view of staff recruitment and commodities procurement.

Staff interviews also confirmed that the UNFPA fast-track procedures are very welcome. Some interviewees qualified that nimbler procedures would allow UNFPA to reach its full potential in effectively and efficiently addressing vulnerabilities. Interviewees spoke to the need for UNFPA country offices to be able to quickly re-programme resources, acquire new implementing partners and rapidly disburse funds to local partners who may or may not have bank accounts. Furthermore, they suggested that country offices should have greater flexibility to create field offices and open warehouses, for example. It was also suggested that operations staff need to better understand the importance of prioritizing fast-track procedures. Going a step further, another suggestion was to automatically activate the fast-track procedures for all emergency levels, thus reducing the administrative burden on country office staff.

201 *Inter alia,* Lessons learned, p. 22. Also see survey results regarding human resources.
202 2017 progress report, annex 4; UNFPA Humanitarian Action 2017 Overview.
203 2017 progress report, annex 4.

5. KEY CONCLUSIONS AND SUGGESTIONS

The UNFPA Strategic Plan 2014-2017 and its mid-term review further widened the UNFPA mandate to encompass a stronger focus on, and greater responsibility for, humanitarian programming and particularly preparedness. Since then, the Fund has been in the midst of consolidating its identity as a humanitarian agency, promoting and defending it, and putting it into practise. Even more recently, in 2016, the World Humanitarian Summit coined the term "the new way of working" across the humanitarian-development nexus, adding an additional layer of complexity to the positioning of UNFPA as an international development and humanitarian agency.

Moreover, this transition needs to happen within the difficult context of an increasing number of humanitarian crises and risk of emergencies occurring. UNFPA is expected to make this transition within the context of austerity measures and painful budget cuts.

At the beginning of 2017, UNFPA took on the sole lead of the IASC gender-based violence area of responsibility. Furthermore, the UNFPA Strategic Plan 2018-2021 has introduced an indicator for measuring UNFPA performance as leader and coordinator of humanitarian agencies in the area of sexual and reproductive health and reproductive rights; it also ambitiously envisages UNFPA as a "go to" agency for population data and analysis in humanitarian settings.

Despite impressive results reported in UNFPA annual reports, country programme evaluations and other publications, and appreciation by consulted external stakeholders, the question arises whether UNFPA is not overextending itself and its staff. Is it in a position to live up to the high expectations it is creating in the long run? Is it equipped to do so? How can it do better with what it has? Where does the Fund need to set limits? Where should it set priorities? The following six key conclusions and associated action-oriented suggestions build on the meta-analysis in chapter 4 of the present report and pick up issues that warrant the attention of decision-makers.

CONCLUSION 1:
A fair basis has been laid for UNFPA to position itself strategically and programmatically within the humanitarian-development nexus.

Information gathered points to broad support for the concept of humanitarian-development nexus and similar understandings among UNFPA staff based on their respective experiences. This is a good starting point for the Fund's positioning, based on its comparative advantages. Programmatically, the UNFPA Strategic Plans 2014-2017 and 2018-2021 suggest niche areas where the Fund could make important contributions, such as: integrating MISP in contingency plans; pre-positioning emergency reproductive health kits; (re-)introducing comprehensive reproductive health services; reintegrating and socio-economically empowering gender-based violence survivors; rehabilitating health facilities affected during a crisis; and encouraging youth participation in peace-building processes. Strategically, UNFPA is keen to ensure its presence in relevant networks and initiatives, but lacks a corporate vision or strategy.

Suggestions:

1.2 Develop a strong corporate strategy on working across the humanitarian-development-peace nexus

1.3 Produce case studies on linking development and humanitarian approaches in UNFPA niche areas

1.4 Work towards more flexibility to shift financial resources from emergency to development interventions and vice versa

CONCLUSION 2:
UNFPA humanitarian programming has grown, but funding is not commensurate with population needs, stakeholder expectations and corporate commitments in highly vulnerable contexts.

Globally, UNFPA has clearly emerged as a humanitarian agency. The extent to which this is reflected at country level differs. Asked about hindrances and barriers to sustaining and improving UNFPA contributions to preparedness and resilience in highly vulnerable contexts, inadequate financial (and human) resources rank a clear first. Humanitarian funding, through regular resource allocations, UNFPA emergency response funding mechanisms and other sources, including the CERF, has not kept up with significantly increased requirements, expectations and commitments. UNFPA is not the only one suffering from this fate, however. Even United Nations entities focusing primarily on classic humanitarian assistance, such as WFP, UNCHR, UNRWA and OCHA, have reported significant gaps between requirements and funds received.[9] Reasons for inadequate funding are manifold. A number of them are outside the Fund's sphere of influence. But not all.

Suggestions:

2.1 With the aim of enhancing the capability of country offices to adequately finance their emergency and response plan, including by leveraging additional other resources, use the mid-term review of the UNFPA Strategic Plan 2018-2021 to adapt the UNFPA resource-allocation system by (i) introducing a funding floor and (ii) reflecting better on fragility and risk

2.2 Put a stronger focus on preparedness in UNFPA country programmes to reduce humanitarian needs

2.3 Work towards more flexibility to shift financial resources from development to emergency interventions

2.4 Continue to promote UNFPA as a humanitarian agency

2.5 Continue to promote sexual and reproductive health, reproductive rights and gender-based violence as frontline interventions

2.6 Elaborate a UNFPA-wide resource-mobilization strategy for humanitarian situations

CONCLUSION 3:
UNFPA staff in highly vulnerable contexts are frequently thinly stretched, which impacts on their well-being and performance and the Fund's reputation as a humanitarian actor.

Country office staff are UNFPA figureheads, but many of those working in highly vulnerable contexts are overstretched. In difficult circumstances, staffers are expected to satisfy both long-term development and short-term humanitarian needs, often simultaneously. As a team, programme staff need to be able to competently engage in policy dialogue, advocacy and coordination, besides capacity development and service delivery. Operations staff need to be on top of emergency-related rules and regulations. Ideally, UNFPA should also show presence and leave a mark at sub-national levels and in humanitarian hotspots. Dedicated posts in regional offices, short-term staff and the surge roster are extremely welcome additions, but not the solution, especially not for protracted crisis situations.

Suggestions:

3.1 Review office structuring to meet strategic plan humanitarian requirements

3.2 Ensure adequate presence of dedicated humanitarian staff in priority humanitarian countries

3.3 Capacitate UNFPA staff to work more flexibly across humanitarian and development programmes

CONCLUSION 4:
The roles of UNFPA as leader of sexual and reproductive health and gender-based violence humanitarian coordination are meaningful and appreciated, but lack a solid footing.

This meta-analysis has generated similar lessons for the work of UNFPA to lead and guide programme countries and partners in gender-based violence and sexual and reproductive health humanitarian coordination. Where there are sub-clusters or similar mechanisms at country level, UNFPA has often played a leading role: this is deemed meaningful and has been appreciated. The existence of a global gender-based violence area of responsibility and the formal lead role UNFPA holds therein, is an advantage for the Fund's positioning and prioritization of the problem in vulnerable contexts. However, willingness to be guided by UNFPA, including in protracted crisis situations, depends on stakeholder trust in UNFPA capacities and its capability to represent and lead, which appear inconsistent. In contrast, the ability of UNFPA to coordinate sexual and reproductive health and reproductive rights actors in humanitarian settings is less debateable, but suffers from the fact that sexual and reproductive health and reproductive rights are not an integral part of the humanitarian cluster system and therefore greatly dependent on local priority-setting. In addition, sub-national coordination is gaining importance and adding strain on UNFPA resources.

Suggestions:

4.2 Continue to work towards better recognition of sexual and reproductive health and reproductive rights within the IASC cluster architecture

4.3 Emphasize inclusion of sexual and reproductive health, reproductive rights and gender-based violence in humanitarian contingency plans

4.4 Review and adjust coordination capacities in UNFPA priority humanitarian countries

4.5 Profit from lead roles to promote an integrated approach to sexual and reproductive health and gender-based violence programming in emergencies

CONCLUSION 5:
UNFPA is at a crossroads on whether to invest in becoming a go-to agency for humanitarian data or to accept a more modest role.

There are a number of good examples of ways in which UNFPA has generated and used data for humanitarian programming (for example, census, household surveys, rapid assessments), but UNFPA support for data for humanitarian preparedness and response is less evident than its engagement in sexual and reproductive health, reproductive rights and gender-based violence in emergencies. Under the UNFPA Strategic Plan 2018-2021, there is pressure on for the Fund to claim its place as a go-to agency for data in emergencies. In theory—given its mandate, experience and networks—this stands to reason. In practice, it is questionable whether UNFPA will be able to invest in adequate capacities and expertise to credibly and reliably take on the challenge.

Suggestions:

5.1 Clarify expectations underlying "increasing investment in data in emergencies" as per the UNFPA Strategic Plan 2018-2021

5.2 Update the 2010 UNFPA Guidelines for Data Issues in Humanitarian Crisis Situations

5.3 Ensure availability of adequate expert headquarter/regional office support for country offices

5.4 Explore options to better use/integrate population and development officers in humanitarian programming

CONCLUSION 6:
UNFPA systems and processes for procuring and delivering humanitarian supplies are in need of a revamp.

Leaving aside very good examples of life-saving interventions and activities to maintain the dignity of survivors, the issue of humanitarian procurement remains an area for improvement within UNFPA. Humanitarian procurement is part and parcel of the UNFPA support package for emergency preparedness and response. The most frequently referred-to commodities are emergency reproductive health kits (for which UNFPA is the lead agency internationally) and dignity kits, which have alleviated suffering, saved lives, provided entry points for other interventions, and given visibility to UNFPA as a humanitarian actor. Yet, concerns prevail that emergency procurement could be more strategic, efficient and effective. The ongoing mid-term evaluation of the UNFPA Supplies Programme, a seven-year flagship programme for family planning support to 46 countries, including countries that have experienced/are experiencing humanitarian crises, will identify some lessons and good practices. However, the evaluation will possibly not be sufficient to allow consideration of fundamental corrective measures applicable to highly vulnerable contexts.

Suggestion:

6.1 Commission an independent evaluation of UNFPA humanitarian supplies procurement and delivery