Inter Sectoral Meeting – 5 February 2016

AGENDA

- UNRWA – situation update and priorities for sectors
- Real Time evaluation – SGBV
- Analysis of partner targets and budgets of the LCRP
- Health – analysis of service provision

AGENDA

- **UNRWA – situation update and priorities for sectors**
- **Real Time evaluation – SGBV**
- **Analysis of partner targets and budgets of the LCRP**
- **Health – analysis of service provision**

united nations relief and works agency
for palestine refugees in the near east

وكالة الأمم المتحدة لإغاثة وتشغيل
اللاجئين الفلسطينيين في الشرق الأدنى

Palestine Refugees: Sources

- **Socio Economic Survey of Palestine Refugees in Lebanon** (Preliminary Findings – UNRWA/AUB 2015)
- **Profiling the vulnerability of Palestine Refugees from Syria** (UNRWA/AUB 2014)
- **Post Distribution Monitoring Surveys** (UNRWA April 2014 – April 2015)
- **Intra-household Vulnerability of Palestine refugees from Lebanon and Syria (GENCAP)**

Palestine Refugees: Background

- Palestine refugees depend on UNRWA's services as they are unable to access the public systems in Lebanon.
- Approximately 50% of Palestine Refugees live inside Palestine Refugee camps. The majority of population lives around Beirut and Saida areas with the most insecure camp being Ein El Helweh.
- PRL population: between **260,000 and 280,000** refugees in Lebanon; overall registered is 450,000 refugees.
- PRS population: **40,807 PRS (11,202 families)** as at 29 February 2016 to whom UNRWA is providing lifesaving humanitarian assistance, education and healthcare.
- There has been a **decrease of approximately 5,000 PRS persons** over the past year due to returnees to Syria and migration from Lebanon.

UNRWA Services 2015

In 2015, UNRWA operations in Lebanon provided critical basic services to Palestine refugees, and it:

- delivered basic education to 38,173 students during the 2014-2015 scholastic year;
- provided primary health care services through 27 health centres;
- provided and referred Palestine refugees to specialised protection services and monitored, reported and advocated for Palestine refugees in Lebanon;
- supported 35,946 hospitalization cases for Palestine refugees;
- provided social safety net support to 61,709 abject poor Palestine refugees, as well as access to microfinance initiatives; and
- provided vocational training opportunities to 1,100 young men and women and supported the employability of refugees.

Findings of AUB Survey

Poverty

- PRL: Extreme poverty has halved (3%) although **no significant changes in general poverty** level (65%) from 2010 (66%).

- **90%** of PRS live in poverty (**35,000** could not meet their basic food and non-food needs), and **10%** live in extreme poverty (**3,500** unable to meet essential food requirements). Extreme poverty is three times higher for PRS than PRL.

- Poverty is **highest in the North** (94%) **and Bekaa** (94%), and lowest in Beirut (77%). Extreme poverty in North Lebanon is 15% and in Bekaa 11%.

- Poverty affects young refugees most, with **74% of adolescents living in poverty**, and 5% living in extreme poverty.

- *Poverty line $208 per person per month and extreme poverty line $77 (AUB Survey 2015).*

Findings of AUB Survey

Food Security: PRL

- Food insecurity is assessed using the 7-item Arab Family Food Security Scale; 38% of respondents reported being food secure, 38% moderately food insecure and 24% severely food insecure.
- 27% of children aged under 15 live in severely food insecure households.
- 80% of households reporting severe food insecurity have a head of household who does not hold a Brevet certificate.
- Food insecure households are more likely to include a member with a chronic or acute illness than food secure households.
- Regional trends are different from those reported in 2010, with higher vulnerability to severe food insecurity in CLA, Bekaa and Northern Lebanon in 2015.

Findings of AUB Survey

Food Security: PRS

- Food insecurity is significantly higher for PRS than for PRL households (in line with high poverty rates for PRS).
- Vulnerability of PRS households to food insecurity is high and more similar to the food security profile of Syrian refugees where only 7% of families are food secure in 2015 (VASyr 2015 preliminary data).
- The highest prevalence of any food insecurity is in the Bekaa, with 97% of households reporting they are food insecure.
- In order to cope, 95% of severely food insecure PRS families reported eating less quantity of food than normal.
- Debt is the most frequently used non-food coping strategy, with 81% of severely food insecure families surveyed reporting this strategy.

Findings of AUB Survey

Employment: PRL

- The unemployment rate for PRL is 21% for males and 32% for females.
- The vast majority of the PRL labour force works informally, with less than 14% having an employment contract.
- The main source of income for PRL is self-employment (41%), second source of income is wage labour (38%) followed by UNRWA assistance through the SSN program (33.5%).
- Loans were reported by around 36% of households to be one of the sources of income.
- Remittances represent a source of income for 18% of households.

Findings of AUB Survey

Employment: PRS

- The unemployment rate among PRS reaches a staggering 52.5%, more than double the rate for PRL (23.2%). 68% of females are unemployed compared to 49% of males.

- Similar to PRL, the private sector employs the largest number of PRS across all regions (83%), followed by the NGO sector (1.5%).

- Women are almost 1.5 times less likely to be employed than men.

Access to Work

PRS

- PRS Unemployment rate is 52.5%, **more than double** the rate for PRL (23.2%).
- 53.4% of the employed are paid on a daily basis.
- 97.7% only have **verbal agreements** with their employers.
- **High dependency ratio**: each employed person supports an additional four dependents.
- Four out of five female headed families **do not have any working member** (2014 PRS Vulnerability Assessment).
- **Economic opportunities** for PRS are extremely important to lift them out of poverty, even if provided in the informal economy.

Access to Work

PRL

- All professions, except the senior 'white collar' occupations, report poverty rates of **higher than 50 percent**, reflecting the low pay and precarious work conditions PRL still experience.

- Palestine refugees are still **prohibited** from practicing in several professions.

Findings of AUB Survey

Education: PRL

- Net enrolment has made positive progress as the share of out-of-school children has decreased compared to 2010 survey findings.
- Secondary school enrolment increased significantly to 61% in 2015, from 51% in 2010.
- 97% of school age children are enrolled at the elementary school level, 84% are enrolled in preparatory school and 61% are enrolled in secondary school.
- The average dropout rate for school-aged children is 4%, while the rate of non-attendance is 15%. School dropout rates are associated with socioeconomic status.
- The illiteracy rate is 8%, 11.3% among females and 4.1% among males.

Findings of AUB Survey

Education: PRS

- PRS respondents of schooling age are less likely than PRL to be enrolled in schools across all education cycles
- The majority of PRS attend UNRWA schools, with over 84.6% of students aged 6-12 and 84.2% of students aged 13-15 enrolled in UNRWA educational facilities. 3.9% of children aged 6-18 attend public schools.
- There are significant geographical differences in the rate of secondary school enrolment for PRS, highest in Saida (45.6%) and lowest in NLA (18.6%).
- Female PRS are three times more likely to have never attended school compared to males (9.4% to 3.2%).

Findings of AUB Survey

Health: PRL

- There is a high burden of chronic disease in PRL which places a large financial burden on households.
- Households living in poverty and extreme poverty are significantly more likely to have at least one member with a chronic disease.
- The extremely poor are almost twice as likely to have a family member with a functional disability living in the household.
- Monthly household health expenditure is six time higher in households with at least one chronic disease case.
- 93% of PRL have no health insurance coverage other than UNRWA. Only 5.5% of the PRL population have access to private health insurance, with an additional 1.5% have access to Lebanese National Social Security.

Findings of AUB Survey

Health: PRS

- PRS are almost completely reliant on UNRWA to cover their health needs, with 99% having no access to health insurance other than the coverage by UNRWA for primary health and hospitalization services.

- 85% of PRS respondents report poor mental health, strongly associated with reports of feeling worried about not being able to provide for their families and losing their source of income.

Findings of AUB Survey

Housing: PRL

- The environmental health and housing conditions for the majority of PRL are poor.
- Dampness affects 78% of households, with Tyre having the worst housing condition score.
- About 62% of houses suffer from water leakages and one in ten suffer from severe leakages. 52% suffer from poor ventilation, and 55% is affected by darkness.
- 84% of PRL have access to sufficient water, but water quality is not consistent.

Findings of AUB Survey

Housing: PRS

- 37.4% of PRS households reported moving house in the past year; with 15.7% moving once, 11.6% twice, and 9.6% three to five times.

- 46.2% of PRS households reported living in overcrowded conditions with more than 3 people sleeping per room.

- With an average number of 4.34 persons per room, overcrowding is most severe for households in Bekaa. More than half of the residents (54.1%) live in dwellings that are very small; 40m^2 or less.

UNRWA Priorities 2016 - 21

Over the course of the agency's Medium Term Strategy from 2016-21, UNRWA will continue to:-

- deliver its basic services in education, health, relief and social services and camp improvement;
- mainstream protection into its programmatic interventions;
- support hospitalisation for Palestine ;
- develop relevant approaches to support early recovery, livelihoods and vulnerable refugees;
- support the employability of refugees through targeted vocational training and advocacy with the relevant stakeholders to promote employment of Palestine refugees from Lebanon; and
- respond to the impact of regional and localised conflict and displacement of Palestine refugees.

Health Priorities

- Support for UNRWA **health centres' operations and broader health services to the community,** including awareness raising campaigns.

- Support **improvement of services** and coverage of beneficiaries. Including men's health, maternal and child health, participating in the National polio campaigns, rehabilitation of health centres.

- **Support for Hospital services** for Palestine refugees.

- Support initiatives in **Gender Based Violence and Mental Health and Psychosocial Support, particularly to strengthen the referral system in Lebanon**.

Health Priorities

- **Expand referral systems** (including MHPSS) and partnerships in order to widen access to cost effective health services for Palestine refugees.

- UNRWA will seek **partnerships** with national and international partners in particular for access to hospitalisation for the most vulnerable.

- Significant partnerships already exist such as UNICEF to support vaccination and maternal and child health.

Education Priorities

- Ensuring that Palestine refugee children who are affected by conflict or are out of school are not deprived of from the right to education.

- Support for inclusive education practices and services for children with special needs in Lebanon.

Food Security Priorities

- Support for abject poor Palestine refugees to meet their basic food needs. (UNRWA plans to continue providing Social Safety Net assistance to approximately 61,709 beneficiaries).

Livelihoods Priorities

- Support Technical and Vocational training.
- Engage with local and regional employers.
- Strengthen and expand the provision of career guidance services.
- Provide individual University scholarships for Palestine refugees and
- Advocate for refugees' legal right to work, where this is restricted.

WASH Priorities

- Provide awareness to refugees on water use, solid waste management, ensuring healthy environment.

- Support projects addressing water resource, supply and networks, sewerage networks and water drainage in camps that suffer from deteriorated environmental infrastructure conditions.

Conclusion

- UNRWA looks forward to engagement with the sectors to support Palestine Refugees' from Syria and the PRL host community.

- UNRWA remains committed, with the support of key partners, to ensuring continued quality services to Palestine refugees.

AGENDA

- UNRWA – situation update and priorities for sectors
- Real Time evaluation – SGBV
- Analysis of partner targets and budgets of the LCRP
- Health – analysis of service provision

OVERVIEW OF THE EVALUATION

Implementation of the IASC GBV Guidelines for the Prevention and Response to GBV in Emergencies in the Syria Crisis Response.

2015

Background

- Are we Listening? IRC Report
- Regional GBV Network agreed this is important issue to look into and Steering Committee formed. Led by **UNFPA and UNHCR, in coordination with UNICEF, IRC and IMC and the GBV AoR**
- Developed concept note for funding

Aim of the evaluation

- To examine the humanitarian community's implementation of global guidance on GBV prevention and response

- To inform the roll out of the Revised Guidelines

- To support the 3RP and SRP processes

The aim was not to :

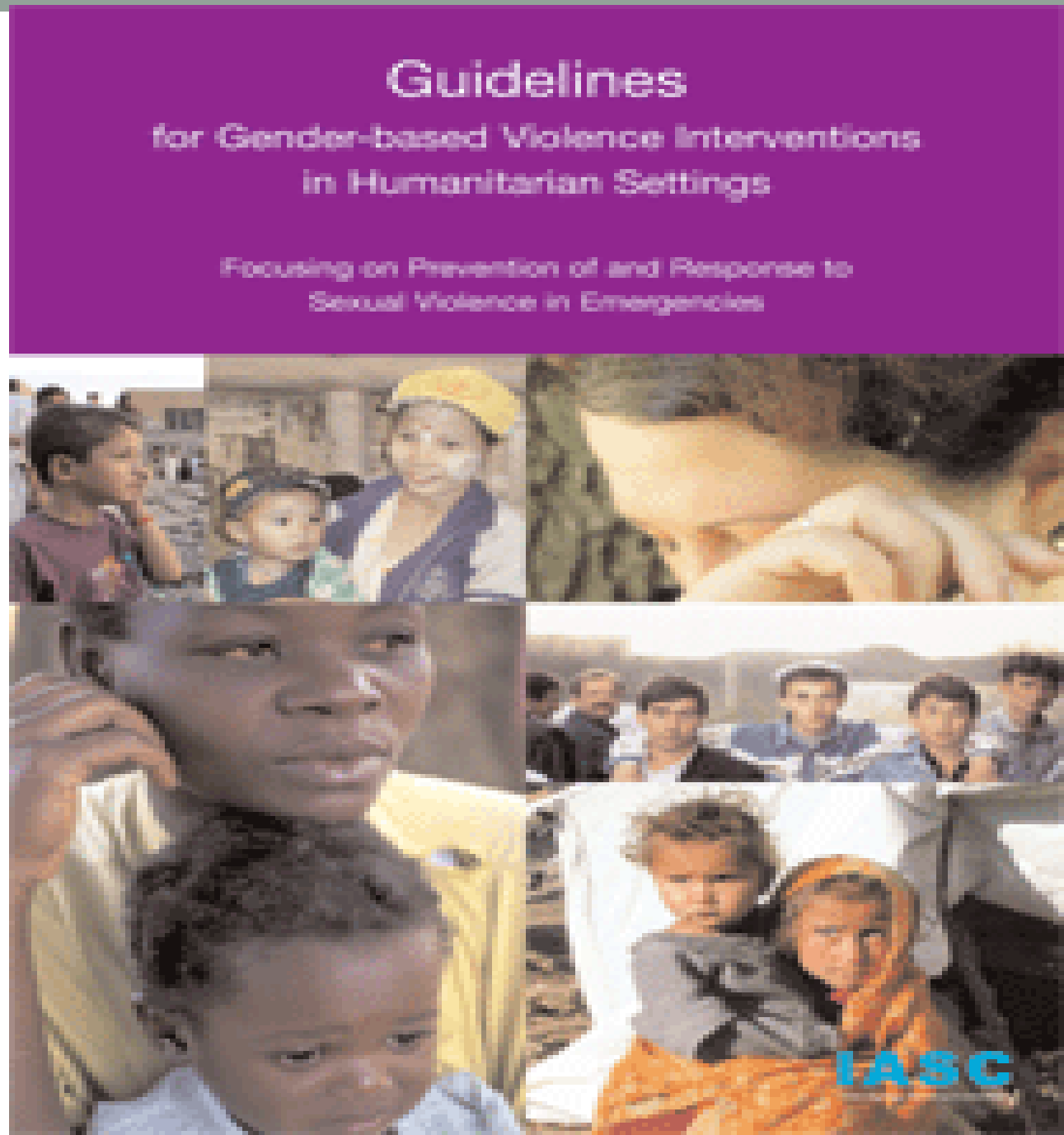
- put blame on organisations or agencies or specific projects
- Identify survivors or be a prevalence study

Benchmark

- Inter-Agency Standing Committee (IASC) Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies., IASC, 2005

=

IASC GBV Guidelines



The specific objectives

- **To evaluate the extent to which the 2005 Guidelines were referred** to and used in assessment and selection, design, monitoring and evaluation of programs across humanitarian sectors.

- **To identify the challenges and the facilitating factors** in implementation of the 2005 Guidelines in the Syria situation in order to directly inform the roll out and implementation process for the 2015 Guidelines;

- To examine the extent to which sectors were held **accountable** for adhering to the 2005 Guidelines (whether any actions were taken if sectors did not adhere to the guidelines, e.g.);

- To determine whether **donors** referred to and used the 2005 Guidelines to decide on funding allocations in specific sectors and how.

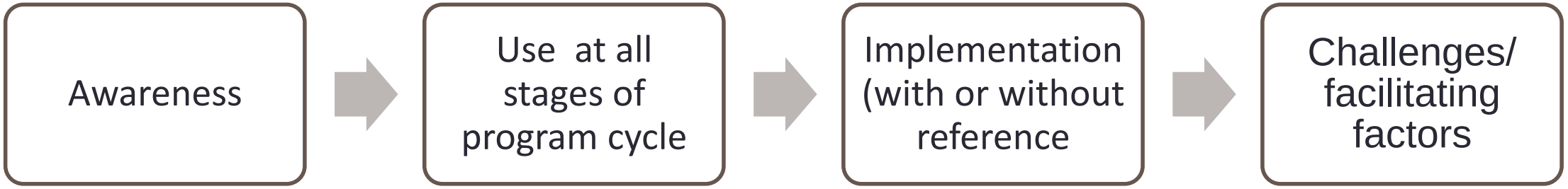
Evaluation Methodology.

- 4 Operations chosen based on refugee response and interest
  - Lebanon, Jordan, Iraq (KR-I) and Northern Syria Operations
- 2 Sectors / Country
  - Chosen by asking SGBV/GBV workings groups to name their top three sectors that they would like involved in the evaluation

Country	Shelter	Health	WASH
Lebanon	✓	✓	
Northern Syria		✓	✓
Iraq (Kurdistan region)		✓	✓
Jordan	✓	✓	

Evaluation methodology - tools

- Key informant questionnaire for WASG, Health, Shelter



- Focus Group Discussion Guides (for W/G/B/M), focused on

- Do[illegible]aire
- Data Collection Guide

Field Evaluation

- Conducted by Lead consultant in Jordan and Lebanon and by REGAs in Northern Syria and Iraq over May, June and July 2015
- 5 days in each country
- 72 Key informant Interviews and 23 community focus group discussions.
- Donors interviewed were DFID, OFDA, ECHO and BPRM
- Report compiled and produced by lead consultant.

Desk Review

- Looked at the extent to which, gender-based violence (GBV) interventions are explicitly mainstreamed into Health, WASH and Health sectors in the regional appeals for the Syria crisis response,
  - RRP1 – 6
  - 3RP
  - SRP
  - And some of the sector strategies.

- Conducted by the DFID Violence Against Women and Girl Helpdesk

Limitations

- Only 5 days per field evaluation (excluding travel)
- 3 different evaluators
- 2 sectors per country
- No FGD in Northern Syria
- Ramadan
- Not able to meet every donors in every country

KEY FINDINGS

FINDING 1: The IASC Guidelines for the Prevention of and Response to GBV are not well known and are not being used in programming practice.

FINDING 2: The GBV Guidelines are not incorporated consistently in organizational or sector-specific strategic documents and standards.

FINDING 3: Sectors are not held accountable for failing to incorporate the GBV response and prevention minimum standards outlined in the GBV Guidelines.

FINDING 4: Sectors expect and assume that SGBV Working Groups/ GBV sub-clusters are exclusively responsible for sensitization, monitoring and implementation of the GBV Guidelines.

FINDING 5: Sectors rarely include, engage with or hold themselves accountable to women and girls in a meaningful, consistent and routine manner

What stops the sectors from incorporating all key actions?

External challenges :

- Problems of access (service providers to certain sites, beneficiaries to the facilities)
- Synchronisation with national policies
- Limited funding and resources
- Cultural barriers (talking to unmarried women about sexual violence0

INTERNAL CHALLENGES (SELECTED)

- Lack of detailed knowledge of the key actions/weak capacity
- Current GBV guidelines leave grey areas (especially relevant for shelter and WASH in urban areas and ITS)
- Minimum standards of GBV prevention and response and other guidance by sectors are often not synchronised
- Absence of strong mechanisms for measuring the accountability.

FACILITATING FACTORS AND GOOD PRACTICES

- **Safety audits** by GBV actors
- **Joint inter cluster strategie**s like in the health/ GBV strategy from Northern Syria
- **Capacity building** in Health sector in Jordan and Lebanon
- Having well established **Standard Operating Procedures** that are developed with all sectors and outline responsibilities clearly
- Having **reproductive health well integrated into the primary health care system**
- Having the **GBV Information Management system well established** and analyzed

RECOMMENDATIONS

1. Humanitarian Coordinators and Refugee Coordinators should:

- Remind all that they have a responsibility to integrate GBV risk reduction in their strategies and proposals.

- Require regular monitor updates during HCT/ICWG/ISWG meetings on actions taken to prevent, mitigate and respond to GBV.

2. Humanitarian Country Teams, Inter sectors / cluster working groups/ ISCCG

- Instruct and support all cluster/sector lead agencies to facilitate joint, multi-sectoral workshops on the IASC GBV Guidelines

- Require each cluster and sector to incorporate and adhere to the GBV Guidelines throughout each phase of the Humanitarian Program Cycle

- Regularly discuss GBV risks and risk reduction responses in inter cluster/sector meetings, highlighting opportunities for joint cluster/sector approaches to prevent, mitigate and respond to GBV.

2. HCT, ISWG/ICWG, ISCCG continued.

- Develop and implement an accountability framework for affected populations
- Seek resources, with support from the HC by the end of 2015, for developing a GBV Guidelines implementation monitoring plan for 2016
- conduct a follow-up real-time evaluation on the implementation of the new IASC GBV guidelines in each country within 18 months.

3. Cluster/ Sectors Leads (including WoS) should:

- Incorporate questions related to risks of GBV in their respective sectoral assessments
- Identify GBV risk reduction priorities based on sectoral assessments
- Ensure that GBV prevention and mitigation actions are included in cluster/sector strategies.
- Integrate relevant, contextualized indicators from the guidelines into regular cluster/ sector monitoring activities
- Designate Focal point responsible for monitoring
- Ensure agencies, disseminate, channel resources towards and train staff on a regular basis on GBV risk reduction

Donors should:

- Require that funding proposals from all sectors outline specific GBV risk reduction activities and include these measures in partner reporting requirements and monitoring and evaluation plans.

- Hold accountable any partners who fail to adhere to and implement the GBV Guidelines, including through the implementation of a program improvement plan as well as restrictions on future funding opportunities if partners fail to meet requirements.

5. GBV SC/SGBV WG should:

- Provide ongoing support to cluster/sector staff on meeting their responsibilities outlined in the Guidelines.
- Lead on raising awareness of the Guidelines in Country.
- Conduct training on the guidelines.
- Conduct safety audits and encourage clusters/sectors to implement and follow up on the recommendations of the safety audit.

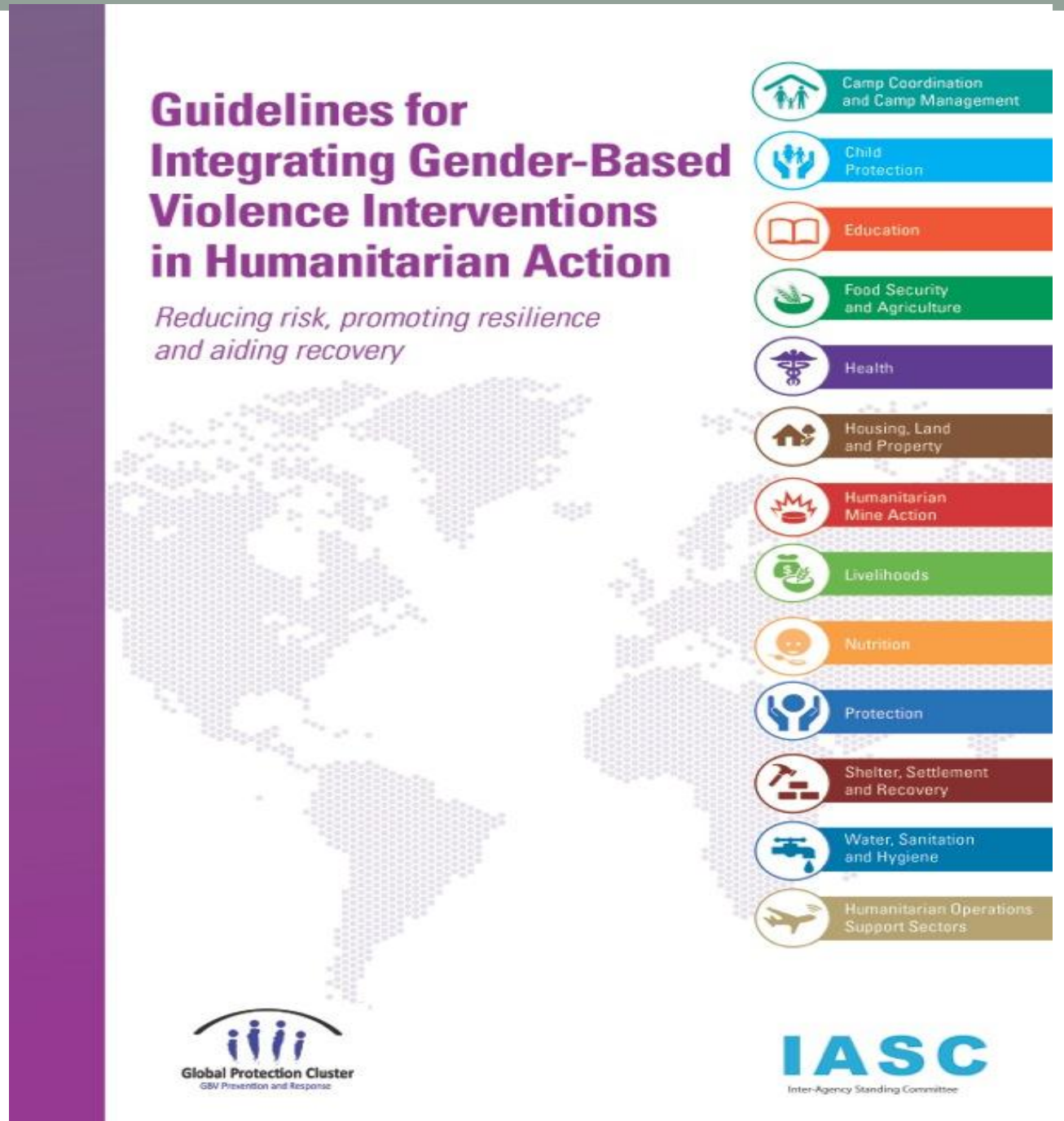
6. All humanitarian actors should

- Ensure regular, consistent and systematic conversations - safely and ethically- with women and girls separate from men and boys, as well as regular feedback loops to share what specific actions were taken to respond to their unique and specific needs.

- Raise awareness and advocate for the uptake of the GBV Guidelines by all international, national and local partners involved in humanitarian response.

What's next?

- Dissemination workshops in country
- In country roll out of the revised guidelines
- Support from the steering committee
- Donor briefings
- RTE of roll out of the revised guidelines



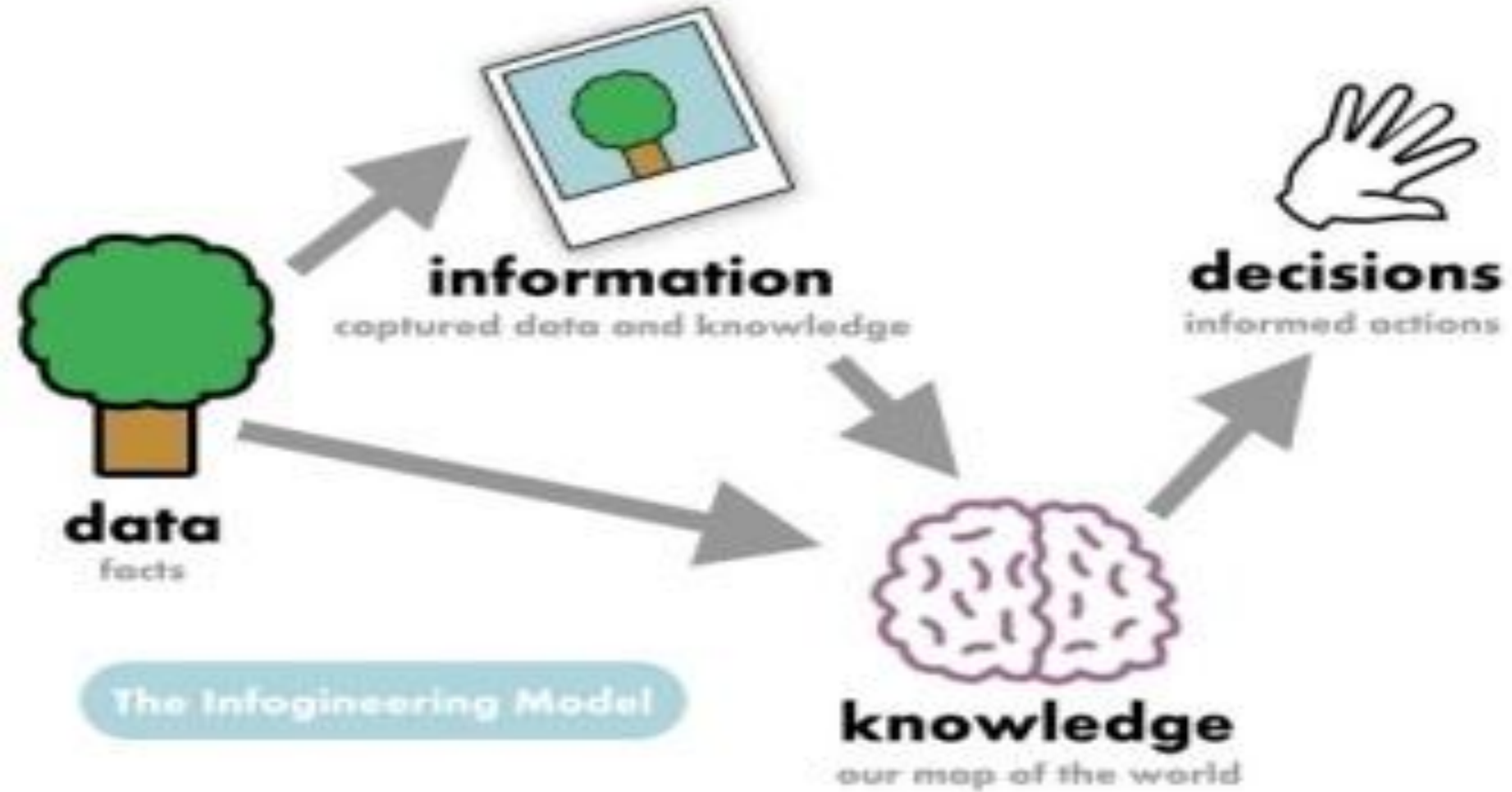
AGENDA

- UNRWA – situation update and priorities for sectors
- Real Time evaluation – SGBV
- Analysis of partner targets and budgets of the LCRP
- Health – analysis of service provision

AGENDA

- UNRWA – situation update and priorities for sectors
- Real Time evaluation – SGBV
- Analysis of partner targets and budgets of the LCRP
- Health – analysis of service provision

Mapping Primary Health Care Services



Background Information

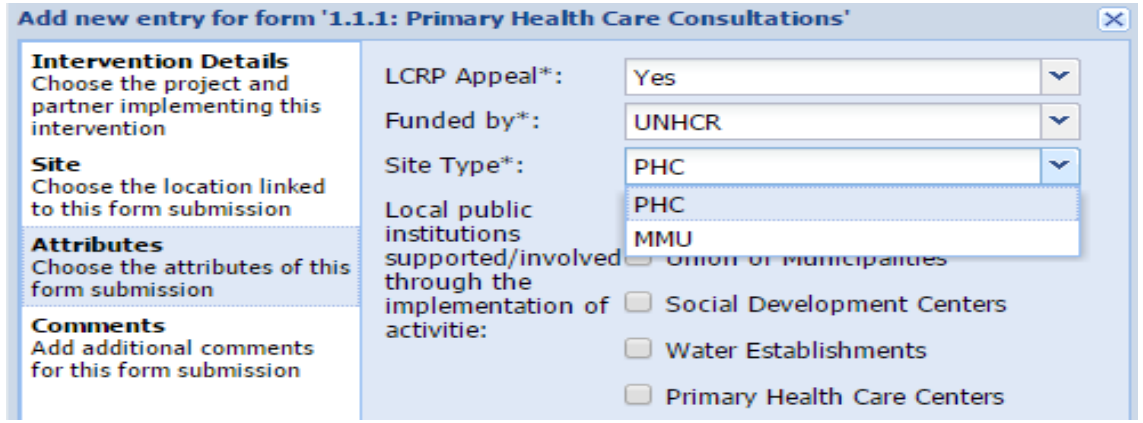
LCRP 2016 Health Chapter

- Ensure access to PHC primarily through MoPH-PHC network but also through centers outside the MoPH network
- Strongly discourage the creation of additional costly parallel health care structures = both displaced Syrian and vulnerable Lebanese should benefit from the same entry points

Source of Information

Activity Info **LCRP 2016 R - Health** (January)

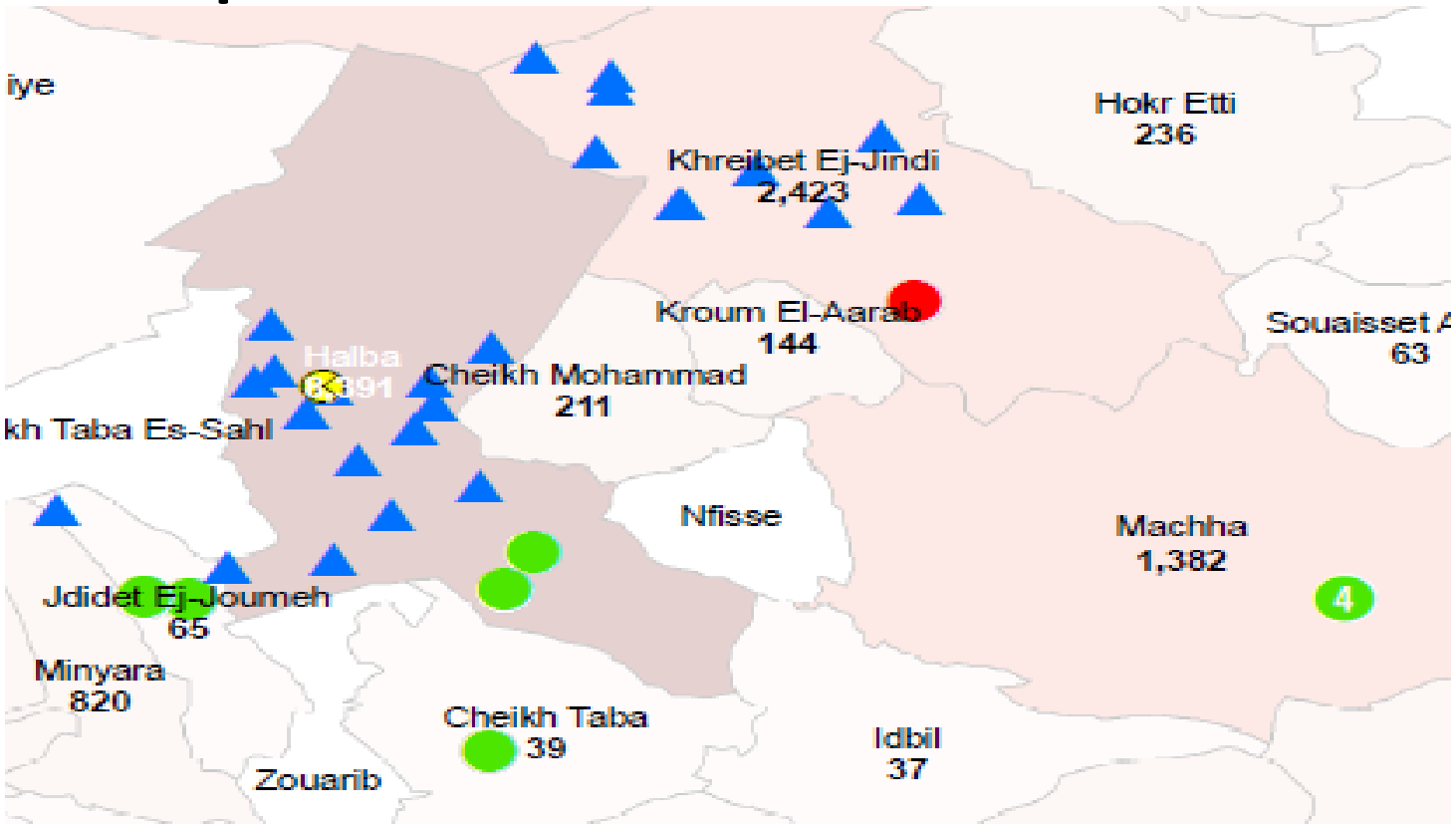
Ability to capture primary health care services being provided by PHCs v/s MMUs



Ability to verify/validate this information

Site.Type	locationName
PHC	IS: Aamayer Ouadi Khaled 008
PHC	IS: Ouadi El-Jamous 020
PHC	LOC: Tariq El Jdide
PHC	LOC: Moussaitbe
PHC	LOC: Kfar Hamam

Capture from Akkar Gov.



MMU sites reported by partners (103 Sites)

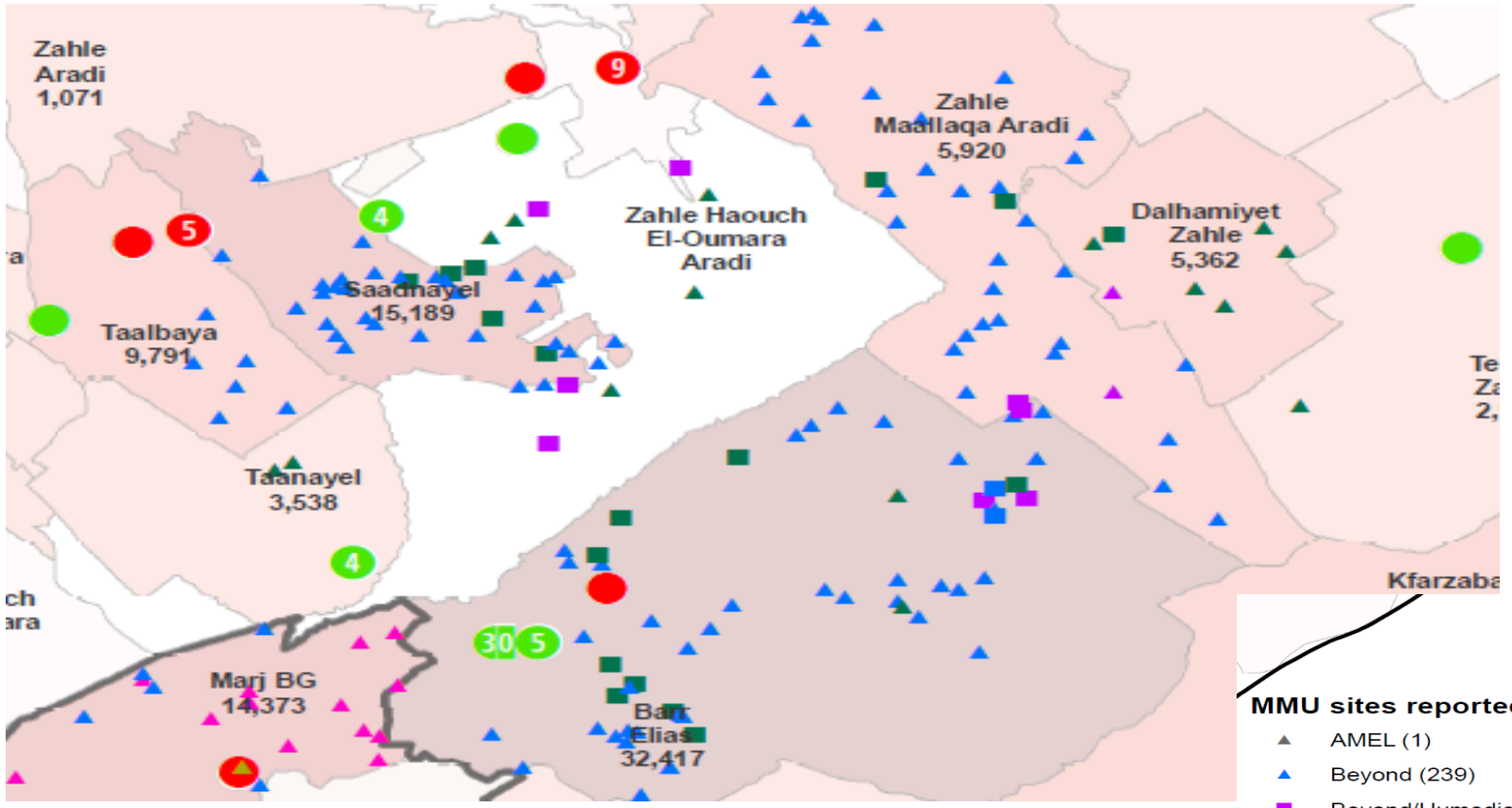
- Beyond (79)
- MAP-UK (1)
- Makassed (1)
- RI (22)

- SDC (16 Centers)
- PHCs within MOPH network, Supported by partner (6/21)
- PHCs outside MOPH network, Supported by partner (0/6)

Partners reporting under PHC

	Partners
④	IMC

Capture from Bekaa Gov.



MMU sites reported by partners (335 Sites)

- AMEL (1)
- Beyond (239)
- Beyond/Humedica (5)
- Beyond/Humedica/Medical Teams International (3)
- Beyond/Medical Teams International (21)
- Humedica (2)
- Humedica/Medical Teams International (3)
- MDM (1)
- Makassed (1)
- Medical Teams International (22)
- RI (37)

- SDC (12 Centers)
- PHCs within MOPH network, Supported by partner (5/20)
- PHCs outside MOPH network, Supported by partner (6/16)

Partners reporting under PHC

	Partners
①	AMEL
③	FPSC - Lebanon
④	IMC
⑤	IOM
⑧	MDM
⑨	MEDAIR

Key Observations

- MMUs are visiting many sites which are less than 1 or 2 kms away from the closest PHC
- Some sites are being visited by multiple MMU partners
- Some PHCs are being supported by more than 1 partner
- Many supported PHCs are not within the MoPH network
- There is an information gap relative to the monthly achievements of non-supported PHCs or SDCs

Thank You!